Designing and Evaluating a Psycho-educational Intervention for Compulsive Shopping

By
Megan Garner

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Abstract

Compulsive shopping is defined as repetitive purchasing behaviour performed in response to negative affect providing short-term gratification and alleviation of negative emotions. The positive effects of shopping are short-lived and often replaced by feelings of guilt, regret and depression. Compulsive shopping causes personal distress including social and vocational functioning, marital and family disruption and financial problems including bankruptcy and debt. Compulsive shopping is discussed in relation to four theoretical models 1) *Escape from Self-awareness*, 2) *Self-regulation Failure*, 3) *Distortion of Autonomy*, and 4) *Negative Affect Regulation*. These models conceptualise compulsive shopping in terms of mood regulation achieved through avoidant-style coping strategies. Based on these theories and prior research a psycho-educational intervention program was designed and administered to five compulsive shoppers teaching self-awareness, approach style-coping strategies and mood regulation techniques. The efficacy of the intervention programme was evaluated. Support was gained for the three hypotheses investigated.

H1: *Negative Mood*: Compulsive shoppers will score higher on tests on anxiety, depression and stress and lower on tests evaluating self-efficacy.

H2: *Avoidance Coping*: Compulsive shoppers will utilise more avoidant-style and emotion focussed strategies to deal with life stressors.

H3: *Augmented Improvement*: Negative emotional states will decrease in frequency and/or intensity, and the frequency of shopping will decrease as the techniques teaching approach-style strategies are regularly applied by the participants.

At the completion of the intervention and at one-month follow-up all 5 participants had significantly reduced in their frequency of compulsive shopping and were no longer classified as compulsive shoppers by the Compulsive Buying Scale (Faber & O'Guinn, 1992). All participants improved their active-coping skills, and showed significant improvements in psychological tests measuring depression, anxiety, stress and general health. Qualitative data in the form of interviews and daily diaries gave further understanding of the antecedents and subjective experience of the participants, during and after a compulsive shop.

Chapter One
Introduction and Overview

Designing and Evaluating a Psycho-educational Intervention for Compulsive Shopping.

Chapter 1.1: Introduction and Overview

Compulsive Shopping was first identified by Kraeplin (1915) and later by Bleuler (1924) as buying mania or oniomania and was described as a pathological or reactive impulse (Lejoyeux, Tassain, Solomon & Ades, 1997). Despite the relatively long recognition of this disorder it still lacks a standardised name some 73 years after it was discovered. The various terms used in the research literature to refer to the phenomenon of compulsive shopping include compulsive buying, compulsive consumption, oniomania, addictive buying and addictive shopping.

The difficulty of adopting a standard term does not appear to lie in the definition of the behaviour but rather in its classification. A comprehensive definition of compulsive shopping based on the phenomenological data reported in research is given below. The classification debate is about whether compulsive shopping should be classified as 1) an Impulse Control Disorder (ICD); 2) an Obsessive Compulsive Disorder (OCD); 3) a subcategory of OCD or 4) as an addictive disorder. This debate is discussed in detail below after the presentation of the phenomenological data.

In general, researchers define compulsive shopping as experiencing irresistible urges to buy resulting in repetitive purchasing that becomes a primary response to negative events or feelings. The purchasing activity provides short-term positive rewards in the form of tension relief and gratification although these positive gains are often short lived and replaced by feelings of guilt, regret, helplessness and depression. The behaviour is difficult to stop and ultimately results in harmful consequences. These consequences include personal distress, interference with social and vocational functioning, marital and family disruption and financial problems including bankruptcy and debt (Christenson, Faber, de Zwaan, Raymond, Specker, Erken, Mackenzie, Crosby, Crow, Eckert, Mussel & Mitchel, 1994; Engel, Blackwell & Minard, 1995; O'Guinn & Faber, 1989; Valence, d'Astrous & Fortier, 1988).

1.2 Definition and Diagnostic Criteria

The definition and criteria for diagnosis of compulsive shopping is not included in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987), although the following diagnostic criteria were advanced by McElroy, Keck, Pope, Smith and Strakowski (1994).

A. Maladaptive preoccupation with buying or shopping, or maladaptive buying or shopping impulses or behaviour, as indicated by at least one of the following;

i. Frequent preoccupation with buying or impulses to buy that is/are experienced as irresistible, intrusive, and/or senseless.

ii. Frequent buying of more than can be afforded, frequent buying of items that are not needed, or shopping for longer periods of time than intended.

B. The buying preoccupations, impulses, or behaviours cause marked distress, are time consuming, significantly interfere with social or occupational functioning, or result in financial problems (e.g. debt or bankruptcy).

C. The excessive buying or shopping behaviour does not occur exclusively during periods of hypomania or mania.

The diagnosis of compulsive shopping maybe based on the above criteria, and may also include results from a specific questionnaire that was designed for the assessment of compulsive buying among psychiatric patients (Lejoyeux et al., 1997) and through the Compulsive Buying Scale (Faber & O'Guinn, 1992). Other scales and interviews designed to evaluate buying behaviour, self-esteem, impulse control, compulsiveness and

depression have also been used (Christenson et al., 1994; d'Astous, 1990; Faber & O'Guinn, 1992). However there is still a need for a standardised diagnostic scheme to ensure effective diagnosis of those who are in need of therapy and to facilitate research, by ensuring that all participants identified in studies as compulsive shoppers have the same diagnostic status. Note, however, that development of an agreed diagnostic scheme will not remove the necessity of conducting a careful functional analysis of each case to establish the variables actually maintaining the behaviour for that specific individual (Elliot, 1994).

1.3 Epidemiology of Compulsive Shopping

1.3.1 Prevalence

The prevalence of compulsive shopping in the population was estimated to be as high as 6% by Faber and O'Guinn (1992), although using more conservative methods the same authors later suggested a prevalence of 1%. Elliot (1994) pointed out that these ratings are largely based on self-selected individuals who both recognised that they have a problem and were prepared to come forward. The actual number of individuals who shop compulsively is to a considerable extent unknown. Schlosser, Black, Repertinger and Freet (1994) suggested that the disorder is more common than the research indicates, due to the lack of difficulty they experienced in recruiting participants for their study, and having the majority of the self-identified participants meet the criteria for compulsive shopping. The possibility that compulsive shopping has a higher prevalence rate within specific groups is supported by research that has sampled groups suffering from

depression which report a much higher prevalence of compulsive shopping ranging form 31% to 40% (Lejoyeux, Haberman, Solomon & Ades, 1999; Lejoyeux et al. 1997).

1.3.2 Socio-economic Status (SES)

To date the research does not reveal any firm relationship between socio-economic status and compulsive shopping. It has been suggested that there should be an inverted U-shaped relationship between SES and shopping, in that people in the middle income brackets would shop more than those in lower and upper income brackets, but in general all income brackets seem to be equally represented (Faber & O'Guinn, 1989, Scherhorn, Reisch & Raab, 1990). The level of income does however determine how long the behaviour can be kept secret from the persons' immediate social environment, as friends and family often find out about the behaviour when they are forced to pay the shoppers' debts (Scherhorn et al. 1990).

Research has investigated the relationship between compulsive shopping and number of credit cards owned. Schlosser et al. (1994) reported that only 17% of their participants (N=46) had no credit cards with an outstanding debt. The remaining participants reported having at least one card with an outstanding debt and 7% reported having more than three cards with outstanding debt. The mean debt owed by the participants was $ 5,422, with a large standard deviation of $15,078 due to one participant's having a debt of $100,000, when this outlier was removed the mean became $3448, with a standard deviation of $5366 (Schlosser et al., 1994). McElroy et al., (1994) investigated the amount of debt caused by compulsive shopping in 20 participants and reported a mean debt of $23,000 with a standard deviation of $24,000 (range $3,000 -

$60,000). Therefore the number of credit cards owned and the amount of money owed on the cards seems to vary considerably between compulsive shoppers.

1.3.3 Gender Differences

Investigative research has found that it is predominantly women who seem to suffer from compulsive shopping (Christenson et al., 1994, Scherhorn, et al, 1990). The gender difference found in compulsive shopping has largely been explained in terms of socialisation, in that the socialisation process is likely to determine the type of pathology that an individual develops (Faber, 1992). Support for this argument is evident in the research literature revealing significant gender differences in prevalence rates of major categories of mental disorders. Abbott (1994) reported that males had significantly higher prevalence rates for substance abuse disorders (in particular alcohol abuse/dependence) than females, while females had higher prevalence rates for affective and anxiety disorders than men. Disorders such as kleptomania, trichotillamania and compulsive shopping tends to be effect predominantly females, whereas pyromania, intermittent explosive disorder and pathological gambling effects predominantly males (Christenson, Mackenzie & Mitchell, 1991; Faber and O'Guinn, 1989, & Faber, 1992).

Some of the factors that have been suggested to contribute to the gender difference evident in compulsive shopping include the following.

1. That relative to men, women are exposed to more information about shopping than and are more likely to seek help for their problems and more inclined to answer questionnaires (Faber & O'Guinn, 1989).

2. That shopping is a socially acceptable way for women to use to cope with the strains of life, whereas the use of alcohol to repair mood is more socially acceptable (until it becomes very extreme) for men than it is for women. For instance, a man could go into a pub and drink alone without any social sanction, whereas a woman often could not (Elliot, 1994).
3. Women "develop more passive and more emotional ways of coping with stress and conflicts. Therefore they have a tendency to try and solve their problems secretly and within a perfectly legal and socially desirable framework" (Scherhorn et al. 1990, p.374).
4. Shopping can be justified as part of a 'woman's' role, and the compulsive shopping aspect of it can be kept secret until serious financial consequences arise (Scherhorn et al. 1990).

Socialisation can therefore provide some explanation for the gender differences evident in compulsive shopping and other impulse control disorders, however the disorders are not gender exclusive in that both sexes do suffer from the different disorders even if they disproportionately affect one gender or the other.

1.3.4 Age of Onset and Development

People identified as compulsive shoppers in the research have a mean age of around 36 years, although the ages range from early 20's to late 60's. It is typically reported that the compulsive behaviour develops in the person's late teens but is not viewed as problem until a decade or so later (Schlosser et al., 1994). This realisation is often the result of large debts, inability to pay debts, feedback from acquaintances, feelings of guilt and/or

excessive time and money spent shopping (Christenson et al., 1994; Schlosser et al. 1994). It has been found that although the shopping behaviour is established in the late teens it increases in frequency and magnitude over time (Glatt & Cook, 1987), however this finding was not supported by Scherhorn et al.'s (1990) study. The early onset and late detection stresses the need for effective diagnostic tools in order to identify and treat people with compulsive shopping closer to the onset of the disorder, thereby preventing the long-term consequences of the behaviour.

1.3.4 Self-Esteem

One of the most consistent findings in the literature is a relationship between compulsive shopping behaviour and self-esteem. Generally people who shop compulsively have significantly lower self-esteem than those who do not (Elliot, 1994, & Scherhorn et al., 1990). *"I've always lacked self-confidence and needed to buy things to bolster my self-esteem"* (a quote from a compulsive shopper in Elliot, 1994). Self-esteem was defined by Brockner (1988, cited in Jex & Elacqua, 1999) as 'favourability of an individuals' characteristic self-evaluation'. Hanley and Wilhelm (1991) investigated the difference in levels of self-esteem and attitudes towards money between 43 self-reported compulsive shoppers and 100 normal consumers. The research confirmed that those who shop compulsively had lower self-esteem and believed more strongly in the symbolic ability of money to enhance self-esteem than normal consumers.

Low self-esteem is recognised as being a very important factor in compulsive shopping behaviour, as it is related to the negative emotions that generally lead people to shop

compulsively and influences the types of purchases made. After shopping the person often experiences regret, guilt, depression and helplessness and these act to compound the person's low self-esteem (Faber & O'Guinn; 1989, Valence et al. 1988). This also colours the person's perception of their ability to cope with their negative emotions and stressful situations in other more adaptive ways in the future. Jex and Elacqua (1999) point out that people with low self-esteem are more influenced and effected by environmental stressors than those with high self-esteem and are more likely to use passive forms of coping that focus on mood regulation rather than problem solving strategies.

Whether low self-esteem is a cause or an outcome of compulsive shopping is uncertain (O'Guinn & Faber, 1989). An alternative to viewing self-esteem and compulsive shopping from a 'chicken and the egg' viewpoint it seems that low self-esteem and compulsive shopping behaviour has more of a cyclic and complex relationship. People who shop compulsively are initially low in self-esteem and the negative consequences of the shopping behaviour confirm and reinforce their perceptions, while the short-term consequences of the behaviour increases the likelihood of the behaviour being repeated in the future.

It can be argued that although self-esteem seems to be inherent in compulsive shopping it is not predictive of the behaviour, as low self-esteem can be seen to underlie a number of psychopathological disorders (Christenson, et al. 1994). However even if the variable of self-esteem has no predictive power in determining whether a person will develop

compulsive shopping behaviour, its consistent comorbitiy with the behaviour suggests the existence of a relationship that deserves acknowledgement.

1.3.6 Shopping & Purchases

Generally the purchases made by compulsive shoppers are spontaneous and unplanned (Christenson et al., 1994). Christenson et al. (1994) investigated the frequency and duration of shopping urges. The shopping urges were reported to be experienced episodically and typically lasted for about one hour. The frequency of these urges were different for each participant and ranged from every few days to once a week, although some reported experiencing urges to shop as often as every hour and as infrequently as once a month. Nearly all of the compulsive shoppers reported attempts at resisting these urges although the majority of the time these attempts were unsuccessful. Therefore the frequency of shopping behaviour can vary from everyday, to three times a week or even once a month (Christenson et al., 1994; Elliot, 1994; & McElroy et al. 1994).

The amount of time spent in a shopping episode was on average two hours. When asked why they purchased items shoppers said they would often buy things out of fear that they wouldn't be there later, while others said that they bought items because they felt hassled into it by the sales staff (Elliot, 1994). This reasoning given by compulsive shoppers seems to imply external attributions for their actions, in that it is the external circumstances such as the sales assistants and limited stock that leads them to buy, rather than attributing their actions to internal circumstances such as needing to feel important or attractive.

The information presented above was gathered mainly via a semi-structured or diagnostic interviews conducted with compulsive shoppers and therefore the information gathered was largely retrospective. To enhance the accuracy of the information regarding the frequency and duration of shopping urges as well as the emotions involved with compulsive shopping the information should be collected closer to the occurrence of the event by using mood sampling techniques. One mood sampling technique could involve the participant carrying a pager and when the researcher pages the participant he/she would record the emotions they were experiencing. A diary method would involve the participant writing in a diary while they shopped recording the emotions experienced prior, during and after the shopping experience.

The purchases made by female compulsive shoppers are generally related to appearance, including items such as clothing, makeup, jewellery and shoes. These items are seen to enhance both the self-image of the compulsive shopper as well as others' impressions of them (Christenson et al., 1994; Glatt & Cook, 1987; Hanley, & Wilhelm, 1992). A quote from Elliot's (1994) study illustrates this point. *"My husband left me for a 23 year old and I felt it was because I wasn't very attractive. So I bought expensive clothes to prove that I was."* Other items commonly purchased include household items, books, groceries, electrical appliances and gifts. In a study by Lejoyeux et al. (1999) investigating compulsive shopping, it was found that 50% of the purchases made by participants were self-gifts or gifts to others. Compulsive shoppers also tend to specialise in specific products and buy continually from the same 'favourite' shops (Scherhorn et al., 1990). McElroy et al.'s (1994) study found that the items purchased were generally small and

inexpensive and individually would not cause problems for the participants, however it was the quantity of these purchases that led to the financial and personal distress.

Male compulsive shoppers on the other hand were reported to buy technical appliances, 'extras' for the car, or sporting equipment. In general these items were more expensive and prestigious and were bought in order to "demonstrate that they could afford it, sometimes because they felt they deserved it but mostly because these items served to support their self-worth" (Scherhorn et al. 1990, p. 376). The differences in the purchases made by male and female shoppers are said to be a reflection of gender-identity that is acquired through socialisation (Dittmar, Beattie, & Friese, 1996). Women buy items that have sentimental value, provide emotional comfort and symbolise their relationships with others due to their 'relationship-centred identity.' In contrast, purchases made by men were referred to as being more use and activity related and self-expressive due to their 'activity-centred identity' (Dittmar et al. 1996).

The person who shops compulsively is more likely to associate buying with social status, and one of the most reinforcing aspects of this behaviour is positive interaction with sales assistants and enhanced self-perceptions deriving therefrom. Buying gives the compulsive shopper the feeling of being competent, relaxed or superior. For example *"I don't get pleasure from local shopping. I only buy from shops in town...the staff know me there and the kind of dresses I'll be interested in"* (cited in Elliot, 1994). Although the purchases appear to be bought as a means of enhancing self-image it seems that it is in fact the process of shopping that is gratifying rather than the possession of the items

themselves (Engel et al. 1995). The lack of value placed on the items purchased has been illustrated by the fact that the items are commonly returned, given away or not removed from their packaging (Glatt & Cook, 1987 and Schlosser et al. 1994).

1.3.7 The Emotional Experience

The typical pattern that emerges from the research to date is that the emotional experience prior to shopping is described as involving mounting tension and irresistible urges that can only be relieved by shopping (McElroy et al. 1994). Christenson et al. (1994) found that the intensity of emotional states increased the shoppers' desire to buy. Generally these states were negative (sadness, depression, anger, feeling hurt, loneliness and frustration), though sometimes positive moods such as happiness increased the desire to buy. During the shopping experience feelings of excitement, power and elation were commonly reported. In the majority of cases a release of tension, or gratification was reported following a buying experience (Christenson et al., 1994). However once the shopping was over these positive emotions were generally replaced with feelings of guilt, regret, sadness or anxiety.

1.3.8 Mood Regulation

From the data on emotional experience (Christenson et al., 1994; Elliot, 1994; Faber & O'Guinn, 1992; Scherhorn et al., 1990) it can be inferred that one of the main motivating factors behind shopping behaviour resides in its' ability to regulate negative mood. As illustrated in the quote taken from Elliot's (1994) research *"Ten years ago my husband died and my depression returned. I was away from work for a six months and buying*

something seemed to help the depression for a while." Compulsive Shopping, although ultimately dysfunctional, has immediate positive consequences in that it seems to reliably provide escape from aversive self-awareness and negative emotional states (Baumeister, Heatherton & Tice, 1994; Elliot, 1994). *"I've suffered anxiety for quite a few years...it gave me pleasure to buy things and made me feel better"* (cited in Elliot, 1994). Buying behaviour has been shown to increase during mild to moderately severe depressive episodes and decrease during severe depressive episodes. Depressed compulsive shoppers report that shopping was the only activity that could make them feel better (McElroy et al. 1994). Compulsive shopping has been described as a compensatory behaviour in that it temporarily alleviates depressive symptoms (Lejoyeux, Ades, Tassain, & Solomon, 1996).

In summary, the act of buying is used as a means of coping with unbearable stress, depression, or desperate frustrations, escaping from demands and pressure, or overcoming unpleasant situations, emotions or low-self-esteem (Faber & O'Guinn, 1988, cited in Scherhorn et al., 1990; & Lejoyeux et al., 1996).

1.3.9 Psychiatric Comorbidity

Compulsive shopping has been observed to be comorbid and share similarities with other psychopathological disorders, such as bulimia, kleptomania, life time prevalence of anxiety disorders, depression, pathological gambling, substance abuse, mood disorders, poor impulse control and trichotillomania (the compulsive pulling out of ones' hair) (Fishbain, 1994; Faber, Christenson, de'Zwaan, & Mitchel, 1995; McElroy, Keck &

Phillips, 1995; McElroy, Pope, Hudson, Keck, & White, 1991; McElroy et al., 1994, & Schlosser et al.,1994).

The buying impulses and buying behaviour reported in compulsive shopping share similarities with other obsessive compulsive disorders, the urge to binge eat, irresistible impulses in impulse control disorders, and the drug urges and drug use of substance abuse. Consistent with these findings are those reported by Schlosser et al. (1994). In this study two thirds of the compulsive shoppers (N=46) met the lifetime criteria for a major (Axis 1) mental disorder, most commonly anxiety, substance abuse, eating and mood disorders. Furthermore 60% of the participants were found to meet the DSM-III-R (American Psychiatric Association, 1994) criteria for a personality disorder, namely obsessive-compulsive, borderline, and avoidant types (Schlosser et al., 1994). A study conducted by Black, Repertinger, Gaffney, and Gabel (1998) investigated psychiatric comorbidity in persons with compulsive shopping (N=33) compared with a comparison group (N=22). The results revealed that people who shopped compulsively were more likely to have lifetime mood disorders, especially major depression (60% compared with 27%) and to have more than one psychiatric disorder.

It is important to note that the findings of Christenson et al. (1994) and McElroy et al. (1994) report on average a 53% higher prevalence of major depression than Schlosser et al (1994), and McElroy et al. (1994) reported a 40% higher prevalence of anxiety disorder. This can partly be accounted for by the different methods used by the researchers to recruit participants. Schlosser et al. (1994) and Christenson et al. (1994)

used an advertisement for recruitment, whereas McElroy (1994) selected participants from a psychiatric sample. In conjunction with this Schlosser et al. (1994) administered a computer interactive version of the Diagnostic Interview Schedule rather than a personalised interview, which may have led to under-diagnosis. In spite of these methodological differences the research literature is quite consistent in revealing comorbid disorders with compulsive shopping, suggesting that to find compulsive shoppers who are without psychiatric comorbidity would be rare (Black, Gabel, Schlosser, 1997).

Family history and psychiatric comorbidity in persons with compulsive shopping was investigated and revealed that first degree relatives of compulsive shoppers were significantly more likely than relatives of a comparison group to suffer from depression, alcoholism, or drug abuse and psychiatric disorders in general (Black et al. 1998, & McElroy et al. 1994). Compulsive shopping was identified in 9.5% of the compulsive shopper's first degree relatives, however buying behaviour was not assessed in the comparison relatives. The results of this study suggests that family background and environment play an important role in the development of compulsive shopping, most likely through the process of learning through behavioural modelling. Bandura and Walters (1963) social learning theory emphasises the importance of observational learning in behavioural development. That behaviour is learnt through the combined process of modelling and differential reinforcement.

One limitation of Black et al.'s (1998) study that should be taken into consideration was that the information on the relatives' psychiatric history was based on the descriptions given by the participants rather than by direct interviews of the first degree relatives.

1.3.10 Pharmacological Treatment

Due to the comorbidity of compulsive shopping with other disorders, treatment of compulsive shopping has been predominantly centred on the prescription of drugs that have already been used to treat these comorbid disorders (Kim, 1998; Black, Monahan, & Gabel, 1997; McElroy, 1994). For example Fishbain (1994) states that 'kleptomania might be a non-specific behaviour exhibited with elevated frequency by patients with depression that declines when the underlying depression is treated, and this could also be the case with compulsive shopping patients.' In support of this theory Lejoyeux et al. (1997) found that people who were clinically depressed and shopped compulsively stopped doing so once the depression was no longer present. Likewise McElroy et al. (1994) reports that buying typically increases during mild to moderately severe depressive episodes and decreases during severe depressive episodes.

McElroy, et al. (1994) investigated the effects of various antidepressant drugs (including, fluoxetine, bupropion, nortriptyline, and desipramine) on compulsive shopping behaviour by recruiting 20 participants from clinical settings. Out of the 13 participants who were receiving antidepressant (thymoleptic) medication while symptomatic 9 described complete or partial remission. However due to intolerable side effects several of these drug trials had to be terminated after brief periods of time. The duration of the remission

ranged from 2 weeks to 7 months. Further methodological limitations that should be taken into consideration when evaluating results these include the fact that all participants were from a clinical sample; a variety of thymoleptic drugs were administered to the different participants rather than one standardised drug, and in one case a participant received seven different thymoleptic medications at different times with only two providing partial remission. McElroy et al.'s (1994) study was not single blind and did not include a comparison group.

Other pharmacological studies have been conducted based on the similarities present between compulsive shopping and OCD. Black (1996) investigated the effects of fluvoxamine (a serotonin reuptake inhibitor antidepressant) on buying behaviour in 10 compulsive shoppers. This study comprised of a 1-week single-blind placebo washout followed by 9 weeks of fluvoxamine administration. Nine of the ten participants were considered to be responsive to the drug, based on a 50% improvement on a Compulsive Buying Scale (Faber & O'Guinn, 1992). However this study (Black, 1996) had no follow-up period to investigate whether the improvements were maintained after the completion of the drug trial. It has been reported that behaviour generally returns close to baseline once medication ceases (Black et al., 1994, & McElroy et al. 1994) and researchers suggest further investigation into biological as well as psychological treatments with larger samples. The psychological treatment most commonly suggested but not yet systematically investigated, is cognitive therapy to help combat negative thoughts and unrealistic thinking (Black, 1996; Lejoyeux et al. 1999, & McElroy et al. 1994).

1.4 Classification: Compulsive, Impulsive or Addictive?

Despite the general agreement about and acceptance of this descriptive epidemiological data, it has not yet been agreed as to how to classify compulsive shopping. Whether the disorder is an Impulse Control Disorder (ICD), Obsessive Compulsive Disorder (OCD) a sub category of OCD, or an Addictive Disorder (AD) remains undetermined. The different criteria for each of these classification categories are outlined below as well as the relative advantages and disadvantages of classifying compulsive shopping into one of these discrete categories.

1.4.1 Impulse Control Disorder (ICD)

The DSM III-Revised (American Psychiatric Association, 1987) defines impulse disorders not elsewhere classified as

1. Failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or others.
2. An increasing sense of tension or arousal before committing the act and
3. An experience of pleasure, gratification or release at the time of the act is committed.

In addition there may or may not be resistance to the impulse, that may not be premeditated or planned, and immediately after the act there may or may not be genuine regret, self-reproach or guilt.

Classifying compulsive shopping as an ICD is tempting, as it tends to include the essential features of the behaviour as illustrated in the research literature. Christenson et al. (1994) reports that 95% of their sample described buying behaviours that covered all the DSM III-R criteria for ICD. Schlosser et al. (1994) suggest that compulsive shopping has a lot in common with impulse control disorders as the behaviour is at least initially pleasurable, and the destructive potential of the behaviour only becomes apparent over time and through experience.

However the term 'impulsive' implies a 'time consistent preference', that is, the instigation of a spontaneous desire to commit an act given an opportunity to perform that act (Baumiester & Heatherton, 1996). For example a person can be offered a piece of chocolate cake and then experience a strong 'irresistible' impulse to eat the cake. This 'irresistible' impulse would not be experienced if the cake had never been offered.

Classifying compulsive shopping as an ICD is problematic as it does not account for the core motivation of the behaviour of alleviating negative affect. In the case of impulsive shopping the psychological tension experienced is more likely to be caused by the struggle between desire and willpower at the time of shopping rather than a negative affect experienced prior to the shopping as is typical in compulsive shopping (Valence et al. 1988). It is possible that compulsive shopping begins with impulse buying and eventually this behaviour provides sufficient exposure to reinforcement to become a primary response to negative affect, thereby developing more into a compulsive behaviour (O'Guinn & Faber, 1989).

The plausibility of people who suffer from certain impulse control disorders (such as kleptomania and pathological gambling) as experiencing 'irresistible' impulses has been questioned by McElroy, Hudson, Pope, Keck & Aizley (1992). By definition, such impulses cannot be resisted and therefore refer to things that a person would do 'even with someone holding a gun to their heads and threatening to kill them' (Baumeister & Heatherton, 1996 p.6). These types of impulses do not really exist except in extreme cases of biological functioning such as falling asleep or urinating. Therefore if a person has voluntary control over their impulses perhaps the behaviour would be better classified as a compulsion or as an addiction.

1.4.2 Obsessive Compulsive Disorders (OCD)

Obsessive compulsive disorders (OCD) involve the occurrence of obsessions (recurrent thoughts, ideas or images which are difficult to control and produce distress) and compulsions (repetitive stereotyped behaviours). The content of obsessions generally involve ideas about contamination, illness, aggressive actions and orderliness, whereas compulsions are behaviours which are performed repetitively and in a stereotyped way such as cleaning (Wilson & Edwards, 1996).

Unlike the criteria for ICD, OCD seems to better conceptualise the motivations of compulsive shopping in that the performance of the behaviour provides a means of regulating negative affect, generally anxiety and depression (Christenson et al, 1994; Heatherton & Baumeister, 1991; McElroy et al. 1994; & Schlosser et al. 1994). Research

has also found that people who shop compulsively tend to describe many features that are similar to OCD such as repetitive problematic buying, intrusive thoughts to buy and resistance to such thoughts (Black, 1996, & Schlosser et al., 1994). However a number of studies investigating psychiatric comorbidity have found that very few people who shop compulsively fit the criteria for OCD (Black, 1998; Christenson et al., 1994, & Schlosser et al., 1994). Due to the high rates of multiple obsessions and compulsions reported with OCD, Christenson et al. (1994) argue against classifying compulsive shopping as an OCD but suggest instead that it could be a monosymptomatic variation of OCD.

1.4.3 Addiction

Scherhorn (1990) argues that compulsive shopping is more accurately called an addiction because it involves the extension of normal behaviour in to a pathological habit. He defined addiction as being driven by an irresistible urge which one experiences as ones own will. Whereas compulsion was defined as feeling pressed to do and repeat something even against one's will, for example, compulsive hand washing (Scherhorn, 1990).

Elliot (1994) supports this viewpoint with comments on the biphasic reinforcement effects of compulsive shopping, in that the short-term positive benefits of the behaviour are followed by longer-negative consequences. This biphasic reinforcement in compulsive shopping is said to be a typical of characteristic in addictive behaviour (Marlatt et al., 1988, cited in Elliot, 1994).

According to Scherhorn (1990) in order for a habit to become an addiction it must 1) be based on a considerably low self-esteem; 2) be motivated by a neurotic desire to avoid certain feelings and stimuli which the person experiences as disturbing and dangerous; and 3) be driven by fear of novelty and challenge. While compulsive shopping may fit into the description of this classifying category, it does not seem to fit with the semantics inherent in the word "addiction". Classifying compulsive shopping as an addiction suggests that there is something intrinsic in the act of shopping that makes it addictive. It also makes shopping seem like a substance that one tries to obtain rather than behaviour that one needs to perform. Julien (1998) classifies addiction as a physical dependence on a psychoactive drug, implying that the fear of withdrawal following drug removal is the motivation driving addictive substance abuse.

To clarify the problem of classifying compulsive shopping as an addiction, take the example of smoking. Smoking is classified as an addiction because of the psychoactive dependence that a person develops for the nicotine present in cigarettes. It is true that a smoking addiction may develop out of a habit that is based on low self-esteem and motivated by a desire to avoid certain feelings and driven by a fear of novelty and challenge. However if a person did not have any of these underlying characteristics (e.g. low self-esteem) and began smoking a pack of cigarettes a day for a month (for whatever reason), it is highly likely that by the end of the month (whether they enjoyed smoking or not) they would to some degree be addicted. Whereas if someone was to go out shopping everyday for month (which most people do more or less) it is doubtful that by the end of

the month the person would be a compulsive shopper, as there is nothing inherently addictive about the act of shopping.

The argument that the biphasic nature of reinforcement effects in compulsive shopping (positive short-term consequences followed by delayed negative consequences) is similar to those experienced in addiction (Marlatt et al. 1988) is not so convincing when one looks at the developmental history of compulsive shopping (Christenson et al, 1994, & Schlosser, et al. 1994). The common negative consequences reported in compulsive shopping literature (such as negative affect, financial debt, relationship strain etc...) tend to develop several years after the initial onset of the behaviour and prior to these difficulties the delayed negative consequences do not exist. However it could be argued that equally, delayed negative consequences in the form of withdrawal from drugs do not occur until the physiological adaptations underlying the addiction has had time to develop.

Nataraajan and Goff (1991) suggest a reconceptualisation of compulsive shopping by providing a broader perspective that includes components of addiction and compulsion. This broader conceptualisation of compulsive shopping involves recognition of a continuum having two underlying dimensions.

1) Buying motive, i.e., need, urge, drive, desire.
2) The control over buying.

As both motive and control over buying vary in intensity they give rise to varying buying behaviours. Nataraajan and Goff (1991) state that the primary criterion to determine

whether or not buying behaviour is potentially compulsive is assessing whether or not such behaviour is causing disruption in the normal life of the individual. This reconceptualisation of compulsive shopping is a step in the right direction, however it could be argued that someone's shopping could be defined as compulsive based on the motivations that lay behind the behaviour, without it necessarily causing disruption to their everyday life.

1.4.4 Classification Conclusion

It is apparent that compulsive shopping shares elements with each of these classification categories. However no individual category conceptualises the disorder in an adequate manner. One could debate indefinitely the advantages and disadvantages of adhering to a particular discrete category but this seems a rather futile task. The aim of this section was to present some of the difficulties in classifying compulsive shopping into one of these existing DSM III-R categories and to illustrate the need to devise a new category that could classify the disorder in a more satisfactory manner. Perhaps a more fruitful pursuit would be to understand compulsive shopping within a theoretical framework and then address classification issues from this standpoint.

1.5 Theoretical Models of Compulsive Shopping

A review of the research literature shows that compulsive shopping follows a sequence that is cyclic in nature. There are numerous reports that the people who shop compulsively do so in order to relieve negative affect and that the shopping experience replaces these negative emotions (generally anxiety and depression) with feelings of well

being, contentment, and improved self-image. These positive feelings are however often short-lived and are replaced in time with feelings of guilt, remorse, helplessness and depression (Christenson et al. 1994; Elliot, 1994; & McElroy et al. 1994).

This pattern of behaviour is similar to that displayed in a number of other habitual disorders such as binge eating, compulsive gambling and alcoholism. A number of theories have been put forth by researchers to explain these patterns of behaviour and three of these will be discussed in detail in relation to compulsive shopping. Two related models, the 'Escape from Aversive Self-Awareness' model (Heatherton & Baumeister, 1991), and the 'Self-Regulation Failure' model (Baumeister & Heatherton, 1996, Muraven, Tice & Baumeister, 1998) will be presented, followed by the 'Theory of Distorted Autonomy' (Scherhorn, 1990). Finally a 'Negative Affect Regulation Model' (Garner & Blampied, 2000) that combines the merits of the previous theoretical models into one comprehensive model on compulsive shopping.

1.5.1 Model 1: Escape from Aversive Self-awareness

The *Escape from Aversive Self-awareness* model was designed by Heatherton and Baumeister (1991) to understand the disorder of binge eating. It is argued in this thesis that the similarities between the behavioural and emotional experiences of those who binge-eat and those shop compulsively are consistent enough to justify generalising this model to compulsive shopping.

Heatherton and Baumeister (1991) suggest that binge eating behaviour is motivated by an attempt to escape aversive self-awareness. The model suggests that those who binge-eat evaluate themselves in relation to very high standards and demanding ideals. By viewing oneself in relation to these high ideals and standards makes the person view themselves as deficient or unsatisfactory in comparison. Heatherton and Baumeister (1991) hypothesise that people who binge-eat will generally have a low self-esteem and high aversive self-awareness which will generate negative affect, providing the motivating factor for the escape behaviour (i.e., binge eating).

The escape behaviour is believed to be reinforcing as the aversive self-awareness is refocused and narrowed during a binge episode. That is the person thinks in terms of short-term movements and sensations rather than long-term concerns and meaningful actions. This type of cognitive narrowing will remove inhibitions to keep usual standards. For example, during a binge episode attention is focussed on taste and feel rather than the calorie count and dietary plan.

This escape from self-awareness model shares some conceptual overlap with Strongman's (1984) *Replacement Theory* of stereotyped behaviour. *The replacement theory* states that people are bombarded with more stimuli than they can process at any one time. Cognitive development therefore involves learning how to cope with competing stimulus and response demands through selective attention, therefore learning how to filter out some stimuli and how to deal with the occasional overloading of the system. According to replacement theory, people who show stereotypy have not learned how to

cope with the numerous stimuli encountered in everyday life, creating an aversive feeling of being overwhelmed. Strongman (1984) suggests that stereotyped behaviour tends to develop as a result of the following.

1. A replacement of an aversive behaviour with a behaviour or behavioural sequence that is less aversive.
2. An attempt to replace information that is difficult to process with information that can be dealt with.
3. As an attempt to replace unpalatable beliefs, experiences or feelings with those that are more favourable.

Therefore stereotyped behaviour replaces aversive feelings, thoughts and acts with which the individual cannot cope with feelings and thoughts that are less aversive and can be mastered (Strongman, 1984).

1.5.1.1 Therapeutic Interventions

Based on the *escape from aversive self-awareness* model it was suggested by Heatherton and Baumeister (1991) that treatment (for binge eating in their case) should focus on the cognitive processes that set the escape or avoidance pattern in motion, rather than on the binge behaviour per se. Three main areas of treatment focus were suggested.

1. Attempting to alter the high standards and expectations that place great pressure on the individual.
2. Try to reduce self-denigration and raise self-esteem.
3. Teach cognitive restructuring to help provide the person with an alternative strategy to escape or avoid negative thoughts.

Strongman (1984) likewise suggests that therapeutic intervention should focus on replacing the stereotyped behaviours with more adaptive alternatives, although no specifics were given.

Heatherton and Baumeister (1991) point out that therapy focussed solely on stopping binge behaviour may leave the person with the unchanged motivations and aversive self-awareness, which could cause the person to seek other, possibly more destructive forms of escape. Therefore a more comprehensive approach addressing the various areas of the persons' life, including cognitive, behavioural, social and environmental variables as well as teaching a variety of coping alternatives, would provide more effective therapeutic intervention.

1.5.2 Model 2: Self-Regulation Failure

The model of Self-Regulation Failure is a later model put forth by Baumeister and Heatherton (1996), and was devised to explain how and why some attempts to attain personal goals, plans, or standards succeed while others fail. Baumeister and Heatherton (1996) suggest that the core problem of compulsive shopping, binge-eating, alcoholism and drug addiction is *self-regulation failure*. Their theory of the self-regulation process involves three main phases.

1. *Standard setting*: This first phase involves the setting of clear and consistent standards (ideals or goals) that one would like to achieve. Inappropriate standards, the

lack of standards or having standards that are too high or in conflict with each other will hamper self-regulation.

2. *Self-monitoring*: this refers to the 'test' phase in which the person compares his or her actual state to the standards that have been set. Monitoring one's actions and states is considered to be vital in successful self-regulation. When monitoring ceases, self-regulation tends to suffer, as is evident when considering the effects of alcohol on self-regulation (Baumeister & Heatherton, 1996).

3. *The operate phase:* this occurs out of a reaction to the self-monitoring outcome. If the self-monitoring phase reveals a current state that falls short of the standards, some process is set in motion to change the current state.

It should be noted that these three phases of Baumeister and Heartherton's (1991) self-regulation model share some similarities to Kanfer and Karoly's (1972) earlier model of self-control. This self-control model comprises of a *self-monitoring phase* in which the person notes the antecedents and consequences of their behaviour that act to maintain their behaviour. Followed by *a self-evaluation* phase that involves a comparison between an estimate of performance and an internally set standard. And a *self-reinforcement* (or self-punishment) phase in which a person will self-administer reward (or punishment) to bridge the delay experienced when in external rewards are delayed.

Based on the three phases in the self-regulation model, Heatherton and Baumeister, (1991) identify two types of self-regulation failure. 1) *Underregulation* which refers to failing to take action (e.g., not trying to control one's shopping) and 2) *misregulation* which refers to misguided or inappropriate action (e.g., buying two shirts for $50 instead of one for $27.50).

An important component of this model is *self-regulatory strength.* Self-regulatory strength refers to the cognitive resources that one has available to override, alter, or inhibit responses dictated by habit, learning, situation, or physiology. It is considered to be a limited-attention resource that can be temporarily depleted. At any given time, a person will only be able to regulate so much of his or her behaviour, and when strength is depleted in one sphere, self-regulatory breakdowns are likely to occur in other spheres (Heatherton & Baumeister, 1996). Fatigue and overexertion will also deplete a person's strength and therefore undermine some patterns of self-control (Muraven et al., 1998).

Evidence supporting the notion of short-term depletion can be seen during times of stress. In such situations people become more emotionally irritable, they are more likely to increase smoking, break diets, overeat, and abuse alcohol and drugs (Heatherton & Baumeister, 1996). Furthermore most people are generally more fatigued later in the day, and therefore self-regulation break down should be greater during these times than others. This is supported in Schlosser et al.'s (1994) research on compulsive shopping, which revealed that the majority of compulsive shoppers were likely to shop in the afternoons and evenings more than at any other time.

The theory of *self-regulation theory* shares some commonalty with *the theory of restrained eating* (Herman & Polivy, 1975; Polivy & Herman, 1983). *The restrained eating theory* stipulates that the act of dieting results in overeating. Dieting requires conscience cognitive monitoring to continue to resist food intake despite persistent hunger. The ability to maintain resistance to food consumption and opportunities to eat is reduced by negative emotions, as negative emotions lessen the importance of being slim and over-rides the cognitive restraint. Polivy, Herman and McFarlane (1994) suggest that the negative affect experienced prior to binge eating was related to a threat to ones self-esteem. Therefore compulsive behaviours such as compulsive shopping and binge eating are often performed in an attempt to regulate negative affect or relieve tension (Christenson et al., 1994; Faber 1992; McElroy et al. 1994).

Richards and Gross (1999) investigated the effects of suppressing emotional experience and found that performance on cognitive tasks (memory tasks) were impaired during the suppression period and it was concluded that emotional suppression is a cognitively demanding form of self-regulation. Therefore it is likely that people who compulsive shopping suppress negative emotions until they are no longer able to cognitively maintain the suppression. The lack of suppression ability results in compulsive shopping behaviour which acts to alleviate the negative emotions and the cognitive strain by shifting attention to immediate short-term stimuli such as those available at the local mall (Baumeister & Heatherton, 1996; Parkinson, Totterdell, Briner, & Renynolds, 1996).

Mood states are unable to be altered directly by sheer act of will, and hence the attractiveness of utilising indirect strategies such as shopping or eating to soothe mood. This is an example of *misregulation* where short-term affect regulation is emphasised at the expense of other goals and standards. The paradox that results from such behaviour is that in focusing efforts on emotional regulation, more fundamental and practical aspects of quality of life are neglected, thereby leaving problems unsolved or compounded. The consequences of such actions can be even worse than that which caused the negative affect in the first place (Baumeister & Heatherton 1996).

It is important to consider the costs involved in maintaining self-regulation. Self-regulation may cause acute frustration, withdrawal, and feelings of deprivation. Therefore people will often prefer to give in to their wants rather than undergo the strain of maintaining self-control. Thus both types of self-regulation failure (*under-regulation* and *misregulation*) are examples of avoidance/escape based coping. Lapsing into self-regulation failure is potentiated by dysphoric mood and facilitated by such things as, depleted self-regulatory strength, stress, fatigue and intoxication.

1.5.3 Model 3: Distortion of Autonomy

In the *Distortion of Autonomy* model, Scherhorn (1990) states that compulsive shopping is the result of an attempt to compensate for a distorted autonomy. Autonomy is defined by Shapiro (1981, cited in Scherhorn, 1990) as volitional self-direction which provides the person with a certain independence of outer circumstances. In this view all behaviour ('normal' or symptomatic) is directed by a person's aims, rather than driven by an

internal impulse. Symptomatic behaviour (in this case compulsive shopping) is viewed as escape behaviour; the result of a person trying to inhibit full conscious awareness of feelings or motivations that are in conflict or uncomfortable and that the person has not learnt to face up to and bear. Note the considerable similarities between this theory and the *escape from self-awareness* model (Heatherton and Baumeister, 1991) *and self-regulation failure* model (Baumeister and Heatherton, 1996), in that compulsive shopping provides cognitive and behavioural disengagement from aversive events and emotions.

In the *distortion of autonomy* model, the distortion does not prevent the person behaving in the way he/she wants but causes the actual motivation behind the behaviour to be concealed by regarding his/her actions as 'puzzling' a 'weakness of character' or a 'compulsion' thereby shifting the responsibility of the behaviour onto forces beyond his/her control. This is related to *Attribution theory* as it involves the application of one's own lay theories and causal explanations to make sense of behaviour (Durkin, 1996). Compulsive shopping causing personal distress and financial difficulty therefore the behaviour is likely to be attributed and understood in terms of external influences beyond their control, rather than internal ones as these would imply that the person performs the damaging behaviour intentionally.

Scherhorn's (1990) model suggests that compulsive shopping behaviour is used by the person to escape from uncomfortable feelings and is an act of compensation for low self-esteem. Based on this model the person could face up to the unpleasant feelings or circumstance and find ways to solve or change them. However subjectively this task may

be associated with fear, terror, helplessness and/or inferiority leaving the person no option but to pursue an external support as a substitute for an internal integration.

"The most distinct result of this study was the connection between negative feelings and compulsive shopping, revealing that the compulsive shoppers of this study were profoundly unhappy individuals trying to compensate for and alleviate negative feelings"(Scherhorn, et al. 1990, p.371).

1.5.3.1 Possible Causes of Distortion of Autonomy

Societal Values & Socialisation

The question arises as to how this distortion of autonomy develops. Scherhorn (1990) suggests that, in the modern industrial societies children lack the close relationships which help them to develop autonomy, and consumption is increasingly perceived as a way of effecting compensation through the symbolic significance of the act of buying. It is suggested that the distortion of autonomy is the result of a combination of factors in the socialisation process, although two factors are given particular precedence.

1. *Denial of emotional independence*: to believe that to express certain emotions is frowned upon and to be punished, with the consequence that people get estranged from their feelings and tend to defend themselves from those feelings.
2. *Education into incompetence*: the person is seriously deterred from developing his/her own abilities and from making independent decisions.

The act of buying to add to one's self worth is said to be the result of societal values that place strong emphasis on the symbolic content of consumer goods. Advertising presents many goods with almost magical qualities to solve personal problems and enhance status and well being (e.g., being ill, unloved, unpopular, old, ugly; Scherhorn, 1990). Although these values are transmitted to everybody they will have the biggest impact on those with a lower self-esteem (Scherhorn, et al., 1990). In support of this theory Faber and O'Guinn (1988, cited in Scherhorn, 1990) reported that compulsive shoppers were more likely to be socialised to get along with others and give into people's desires rather than stand by their own opinions. They saw themselves as trying to live up to their parents' expectations, but received little reward for this. It was found in the family of origin of compulsive shoppers that money and gifts were used to reward behaviour with a significantly higher frequency than in other families. Therefore Scherhorn (1990) suggested that compulsive shoppers may have learnt that 'this form of reward may replace or compensate for other signs of caring'.

The development of a distorted autonomy seems therefore, to be the result of the values and behaviours taught and modelled within the family unit, that are in turn compounded and reinforced by the socialisation processes evident in our Western, consumer-based society. Based on the phenomenological data presented earlier with regards to low self-esteem, negative affect and passive forms of coping (Elliot, 1994; Jex & Elacqua, 1999) another factor that could lead to distorted autonomy and compulsive shopping could be the lack of self-efficacy. Self-efficacy refers to the beliefs of an individual regarding the likelihood that a particular course of action or behaviour can be carried out successfully

(Bandura, 1977, cited in Jex and Bliese, 1999). Self-efficacy like self-esteem influences the types of coping strategies used to cope with external and/or internal stressors. High self-efficacy is associated with problem-focussed coping strategies, whereas low self-efficacy is associated with more emotion-focussed strategies (Jex & Bliese, 1999). Faber and O'Guinn (1989) suggest that an intervention for compulsive shopping should involve training in problem-focussed strategies (such as assertiveness) and act to enhance a persons' self-efficacy and confidence enabling them to actively deal with life stressors. Self-efficacy and the different coping styles are discussed in more detail in the intervention rationale section of this thesis presented later.

Key Experiences

Scherhorn (1990) states that compulsive shopping may also develop out of key experiences in adulthood (feeling grand from spending the first self-earned money) or out of more casual repetitive experiences (feeling liked or admired by the sales staff or by other consumers, feeling more complete or improving one's body image and/or acting efficiently).

The shopping experience has been found to give the compulsive shopper solace and consolation, allowing them to feel rewarded. In some cases shopping also gave confirmation of fantasies such as belonging to a particular group, feeling rich or good-looking, well read and noble. For others the shopping experience gave the person a feeling of liberation in that they were in charge of their actions and could forget about the restrictions of their everyday life. Buying provides the compulsive shoppers with a

predictable, reliable, instant satisfaction and provides a feeling of security (Scherhorn et al., 1990; Strongman, 1984).

Faber (1992) is in agreement with the possibility that compulsive shopping develops out of key experiences and offers a social learning explanation. Faber (1992) states that it is likely that many different behaviours would provide the person with the relief and positive affect they seek, which is also consistent with *the escape from self-awareness* model (Heatherton & Baumiester, 1991). However through trial and error or through direct observation and modelling (Bandura and Walters, 1963) compulsive shoppers learn that the act of shopping improves their mood. This leads to more frequent repetition of the behaviour and people eventually become conditioned to repeat the behaviour whenever they seek temporary relief from negative emotions.

1.5.3.2 Restoration of Autonomy: Intervention and Treatment

Self-awareness

Scherhorn (1990) considers that the symptomatic unwanted behaviour, whether it is shopping, eating, drinking or gambling, all seems to 'puzzle' the person acting out the behaviour. Puzzlement arises because distortion of autonomy prevents the person from realising he/she has choices. Scherhorn (1990) believes that the person must first realise the actual aim and the reason behind their symptomatic behaviour (external compensation) in order to create a more active relationship between themselves and the objective aim. Realisation of one's objective has the potential to set the process of autonomy restoration in motion. Once the person is aware of their actual aim they must

also begin to gain awareness of their emotions, placing them in a position to experience and express emotion. This awareness and expression will reduce one of the main factors of distorted autonomy, namely, estrangement from ones' emotions.

Coping Strategies

The next step in the autonomy restoration process would involve the acquisition of new coping skills. In order to apprehend their objective aims and then achieve them, a person needs to learn a repertoire of coping strategies and be taught how to apply them effectively. Elliot (1994) suggests an intervention should begin with a functional analysis of the individual's shopping behaviour to establish the purposes that shopping seems to serve for the individual. Once identified, each precipitating problem should be addressed and training given on how to replace the dysfunctional aid given by shopping with other solutions, together with training in self-monitoring. Elliot (1994) further suggests that cognitive therapy may be used to change the thought patterns that link mood with shopping behaviour. Based on the research literature it becomes apparent that assertiveness training would be beneficial as it would help those who struggle to adhere to their own opinions and not be persuaded by others expectations and social influences (Faber & O'Guinn, 1988). A repertoire of adaptive methods to cope with stress and repair moods is also suggested (Elliot, 1994). These skills would act to restore autonomy by firstly, reducing the client's estrangement from their emotions and gaining emotional independence. Secondly, through education in skills the person would be able to develop their own abilities and make independent decisions (although this restoration is not suggested by Scherhorn, 1990).

1.5.4. Model 4: Negative Affect Regulation Model

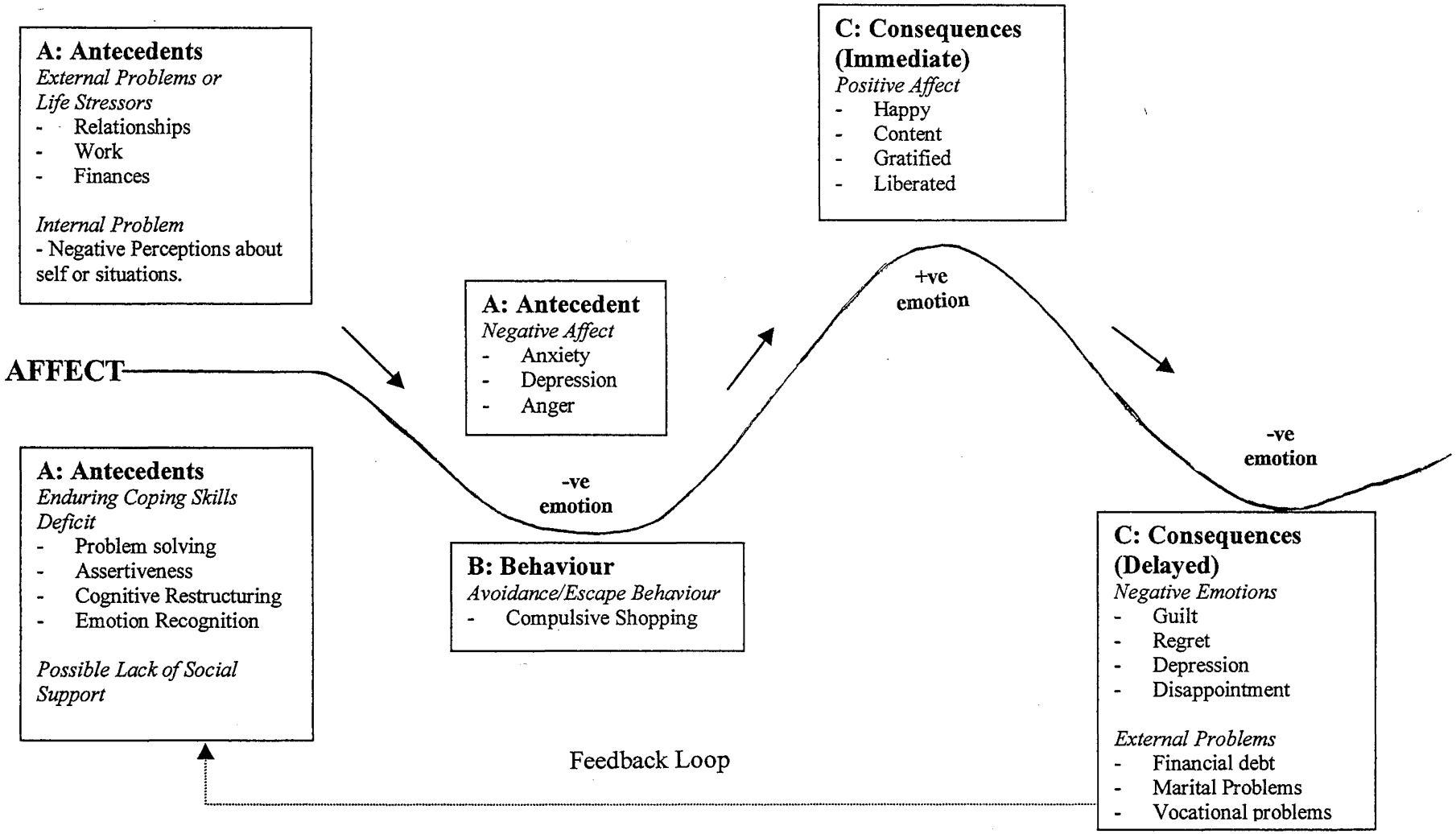

Fig 1. Negative Affect Regulation Model. Displaying the antecedents, behaviour and consequences involved in compulsive shopping and their effect on emotional states.

1.5.4 Model 4: Negative Affect Regulation Model

The *Negative Affect Regulation Model* presented in figure 1 is synthesised from the literature and the three conceptual models presented earlier, *Self-regulation failure, Escape from Aversive Self-awareness* and the *Distortion of Autonomy models.*

Antecedents: External/Internal Problems

The cyclic behaviour constituting compulsive shopping begins with antecedents in the form of external life problems and some level of immediacy or severity. Problems are normal in everyday life, however the person who shops compulsively is likely to lack the coping strategies to face and solve these life problems which leads to chronic negative affect.

The antecedents to compulsive shopping are also negative thoughts that are based on negative perceptions about oneself and one's life. The relationship between negative thoughts and negative mood are explained in Beck's (1970) cognitive triad model of depression. According to this model depression consists of a primary triad of cognitive patterns or schema.

1. Negative view of the world
2. Negative view of the self
3. Negative view of the future

These negative views are developed and maintained by the persons' cognitive distortions, namely;

a) *Selective abstraction*: focussing on detail taken out of more salient context and using it as a basis for conceptualising an entire experience.
b) *Arbitrary inference*: involves a personal interpretation of an ambiguous or personally irrelevant event.
c) *Overgeneralization*: perceiving a single negative event as a never-ending pattern of defeat.

Based on Beck's (1970) model, therapy involves the identification of distortions and then confronting the distortions with the evidence of objective experience.

Antecedents: Lack of Active Coping Skills & Negative Affect

Problematic events are a constant concomitant of life and pose challenges of varying degrees to each individual. Meeting new challenges and dealing with problems is inherent in each person's adjustment to their life circumstances. Varying skills and competencies are required if problems are to be managed and adjustment maintained and enhanced.

Emotions arise in response to an event, either internal or external, that can have either positive or negative meaning for the individual. These organised emotional responses are adaptive and have the potential to initiate positive change in a person's social interaction and lead to enriching experiences if dealt with effectively (Salovey & Mayer, 1989). The

functional relationship evident between a person and the environment leading to emotion has been investigated in terms of a persons' goals and motivations (Lazarus, 1991). Lazarus (1991) contends that emotional experiences is produced out of an adaptational encounter, through the continuous transaction between the person and the environment, in that the person must realise their goals and manage the demands, constraints and opportunities presented in the environment. Central to adaptive encounters and the emotions associated with them is the process of appraisal. Appraisal refers to the ability to sort encounters or relationships into adaptationally relevant equivalence classes that are dependent on the person's goals (Lazarus, 1991). This process to a large extent encapsulates the essence of emotional intelligence, the ability to monitor one's emotions and others feelings and emotions to discriminate among them and to use this information to guide one's thinking and actions in an adaptive way (Goleman, 1996; and Salovey & Mayer, 1989). Individual differences in people's capacity to understand and express emotions have been recognised in clinical settings and it has been suggested that such differences can be alleviated and peoples mental health enhanced by teaching these underlying skills (Salovey & Mayer, 1989).

Research literature suggests that people who shop compulsively do not have an appropriate repertoire of active coping strategies upon which to draw on in order to deal effectively with the problems everyday life (Elliot, 1994). Inability to face and solve problems effectively leads to negative affect (d'Zurilla & Goldfried, 1971) such as anxiety, depression, and helplessness which in turn will compound the person's low self-esteem and other dysphoric moods. It is also possible that even if the person acquires

adaptive copping strategies, due to negative mood states and low self-esteem they may not have the confidence or the state of mind to apply them.

Avoidance Behaviour and its Immediate Consequences

If an encountered problem can not be addressed and dealt with an alternative strategy is to avoid facing it, and instead, work on alleviating the negative emotions that the problem has caused. When difficulties are escaped and avoided, and dysphoric emotions thereby alleviated, the escape/avoidance behaviours are negatively reinforced (Catania, 1968). The behaviour of shopping is both negatively and positively reinforcing in a number of ways.

1. Shopping provides a physical as well as a cognitive escape. The person is able to avoid the situations in which the problem and the related emotions occur by immersing themselves in a distinctly different environment available to them in the mall and/or shop.
2. Shopping provides positive affirming attention from sales assistants that enhances mood.
3. It gives the person the opportunity to buy things that are perceived to benefit their social image. The objects acquired are secondary (conditioned) reinforcers established by direct or vicarious experience.
4. Being able to buy these items has the effect of making them feel happy and in control.
5. All these aspects work together to improve their emotions and enhance their self-esteem, usually resulting in feelings of happiness, gratification, empowerment and contentment.

The fact that compulsive shopping has both positive and negative reinforcement properties greatly increases the likelihood of the behaviour being repeated in the future, and thus developing into a behavioural habit or stereotyped behaviour. Given the frequency of the behaviour and the length of time it has been part of the person's repertoire, compulsive shopping is likely to be a very strong habit by the time the person seeks help for the problem.

Delayed Consequences

The delayed consequences of compulsive shopping involve the replacement of the positive emotions experienced after the shopping experience with feelings of guilt, regret, depression, anxiety and disappointment associated with financial and family problems. It is likely that in the early stages of compulsive shopping (the first few years of the behaviour) these delayed consequences do not occur (or are only mildly experienced). However, later, when the shopping begins to cause financial problems, or debt, or stress on relationships, these delayed consequences become more likely, frequent and severe. It also becomes more likely that the person will realise that their shopping behaviour is problematic and begin to seek help, although initially the help will be sought to alleviate feelings of depression and anxiety rather than to help address their spending behaviour and the circumstances driving it.

The development of long-term negative consequences and accompanying negative emotions is in part due to the fact that at the time they are experienced, the powerful stimuli involved with shopping are no longer present and the person can evaluate their

actions. Anxiety is probably the result of financial concerns and/or the effect their shopping will have on their relationships. Depression may be the result of feeling helpless to stop the behaviour, despite good intentions and promises. Guilt and regret maybe involved if the person is spending money that they owe to someone else or if they are spending money that is perceived as belonging to their spouse or family. Feeling confused and puzzled by their out of control behaviour is probably also common.

These emotions have a negative effect on self-esteem, and having a low self-esteem will only act to compound these feelings. The negative mood regulation cycle is complete when the next precipitating event is encounted and the cycle begins again.

It is important to note that generally researchers do not classify a person as a compulsive shopper if they do not experience negative consequences (Christenson, et al., 1994; McElroy, 1992). However it is argued that even if a person does not experience these delayed consequences their behaviour is still compulsive, provided that the shopping behaviour is frequent, repetitive and is consistently motivated by a desire to alleviate negative emotions. It is likely that the negative consequences of the shopping will eventually develop if the behaviour persists and therefore early detection is important to facilitate in early therapeutic intervention.

1.5.5 Current Research Aims and Hypotheses

Based on the research literature and theoretical models of compulsive shopping discussed above it is apparent that there is a need for the development of an intervention programme that addresses the central problematic antecedents of compulsive shopping, namely; negative mood and avoidant coping styles. Despite suggestions in the research literature for the development of such an intervention programme (Elliot, 1994; Scherhorn, 1990) to date none has not been formulated. Instead the research has predominantly focussed on pharmacological treatments that have shown to have limited success and problematic side effects (Black et al., 1997; Kim, 1998; McElroy et al., 1994).

In contrast, research in the area of eating disorders (specifically binge-eating and bulimia) has developed intervention programmes incorporating self-awareness, cognitive-behavioural therapy (CBT) and mood management and have been found to be effective in alleviating the disordered eating behaviour (Kennedy, Katz, Neitzert, Ralevski, & Mendlowitz, 1995; Telch, 1997; Thackaway, Smith, Bodfish & Meyers, 1993; Wilson, Eldridge, Smith & Niles, 1991; Wolf & Crowther, 1992). It has been argued in this research as well as in previous research (Baumiester & Heatherton, 1996; Heatherton & Baumeister; 1991; McElroy et al., 1995) that there are similarities evident in the antecedents and maintenance of the problematic behaviours of compulsive shopping and eating disorders. Therefore based on the literature illustrating the effectiveness of educational intervention programmes applied to eating disorders it seems logical to design and evaluate the effectiveness of a similar programme for compulsive shopping,

which is the primary aim of this research. A secondary aim is to collect more data relevant to functional analysis of the emotional and situational antecedents that precede compulsive shopping behaviour as is suggested by Elliot (1994). To date the primary method of data collection has been in the form of semi-structured interviews, therefore the primary source of information has been based on retrospective accounts. To elaborate and enhance the present data this current research uses repeated measures taken in the form of daily diaries, requiring the participant to record the situations and emotions prior during and after a compulsive shopping. A further aim of this research is to investigate three hypotheses that have been derived from the research literature and theoretical models presented earlier.

> H1: *Negative Mood*: People who shop compulsively will score higher in tests on anxiety, depression and stress than those in the general population, and lower scores in self-efficacy. Compulsive shopping is performed in an attempt to alleviate these negative emotional states.

> H2: *Avoidance Coping Strategies*: People who shop compulsively will tend to employ more avoidant style coping strategies rather than approach style strategies compared to the general population.

H3: *Augmented Improvement*: As the techniques of approach style coping strategies addressing the management of life stressors, cognitive distortions and emotion regulation are taught to and applied by compulsive shoppers their scores on tests evaluating negative affect and approach coping styles will improve, and their frequency of compulsive shopping will decrease.

The design, administration and effectiveness of the psycho-educational intervention programme used in the current empirical study and the investigation of these three hypotheses are discussed below.

Chapter Two

Rational

Chapter 2.1: Rationale and Methodology for the Psycho-Educational Intervention Programme

2.1.1 Self-Identified Participants

Participants were self-identified volunteers rather than referrals from counsellors, bank managers, budget advisory clinics or other agencies. There were two main reasons for this method of participant selection. Firstly the intervention programme required a large time commitment due to the length of the programme and the amount of homework tasks assigned. Using a self-identification method for recruitment meant that the participants had to recognise that they had a problem themselves and then take active steps to take part in the programme. By using this method it was more likely that the participants would have the dedication and commitment required for successful completion of the course. Secondly the participants may have taken offence and been less compliant if they had been referred to the intervention programme by a third party. Thirdly, due to the programme being new and its effectiveness at the time unknown, agencies or counsellors may have been reluctant to recommend their clients participation.

2.1.2 Research Design: Single Case Research

This research investigated compulsive shopping at the level of the individual in a single-case design format. Shaughnessy and Zechmeister (1994) describe a single case as a natural starting point for a researcher who is entering an area of study about which relatively little is known. Single designs have a number of advantages and allow the effectiveness of therapeutic techniques to be investigated through in depth study of the individual. In this way the various extraneous variables that may be facilitating or

thwarting the intervention can be documented and addressed. The case study also allows relatively rare phenomenon to be investigated (Kratochwill, 1978; Shaughnessy & Zechmeister, 1994) which was useful in this research as the prevalence of compulsive shopping has been estimated at 1% (Faber & O'Guinn, 1994).

Johnston and Pennebaker (1980) state the importance of case studies in psychological research, defining behaviour as the interaction between an individual and his/her environment. Single case research allows a deeper understanding of the specific aspects of an individual's behaviour in terms of past and concurrent experience and processes (Blampied, 1999).

The power of the single-case research design to make causal inferences and conclusions can be increased and the internal and external validity strengthened by employing the following strategies in the research design.

1. *Repeated measures*: Single-case research requires the acquisition of many repeated measures of the dependent variable (compulsive shopping) from a single individual (Blampied, 1999). The participants shopping behaviour was continuously measured throughout the duration of the baseline, intervention and maintenance period.
2. *Manipulation of Independent Variable*: The inferences made in this research are drawn from the direct manipulation of the independent variable (psycho-educational techniques) on the dependent variable (compulsive shopping) during the actual study.

3. *Developmental histories*: The developmental histories of the participants showed long-term duration of the shopping behaviour that had been unresponsive to previous treatment, illustrating stable and persistent problematic behaviour.
4. *Generalisability*: The intervention effect was investigated across several participants with varying characteristics (age, marital status, level of formal education and income) the more variability between participants increases the generalisability of the results (Kratochwill & Joel, 1992).
5. *Intervention Manual*: Each technique taught, the session objectives and homework assignments are clearly described in the intervention manual ensuring consistent implementation (Appendix 1).
6. *Follow-up*: The stability of the changes in the dependent variable (compulsive shopping) was evaluated by including a one-month follow-up session with repeated measures taken during the maintenance period (Blampied, 1999; Chambless & Hollon, 1998; Kendal, 1998; Kratochwill & Joel, 1992).

2.1.3 Multiple Baseline across Participants

The efficacy of the psycho-educational intervention programme was evaluated using a multiple-baseline design across participants (Cooper, Heran & Herward, 1987). This design was used rather than the more traditional sequential withdrawal or reversal designs, due to ethical and practical considerations (Kazdin, 1981). Firstly it would be not be ethical to remove the intervention and allow the participants to return to their baseline behaviour, given the emotional and financial distress this type of shopping behaviour causes. Besides this ethical consideration the intervention is based on therapeutic

instruction and learning which cannot be reversed or withdrawn effectively (Kazdin, 1982; Barlow & Hersen, 1984).

The multiple-baselines across participants requires measurement of the individual's baseline behaviour and then the intervention is introduced to each individual when their behaviour is stable. The participant's behaviour is then monitored throughout the intervention stage to show changes in the target behaviour namely compulsive shopping.

The number of replications contributes to the strength of the study. The more baselines the more powerful the demonstration that the intervention was responsible for the change in the dependent variable. Typically three or more replications are adequate to illustrate the effects of the intervention (Chambles & Hollon, 1998; Kazdin, 1982), however studies using several replications are considered to be stronger experimental designs. The five replications used in this research are considered more than adequate to demonstrate that changes in the shopping behaviour are the result of the intervention.

The five participants had baselines that varied in duration from eleven to seventeen days. The changes that took place when the intervention was implemented are more likely to be due to the intervention rather than extraneous events.

2.1.4 Individual Sessions

The sessions were conducted on an individual basis rather than in small group format. Individual sessions were believed to be more effective as they enabled rapport to be

developed quickly between the researcher and the participant and facilitated identification of the reasons that lay behind the shopping behaviour. The reasons and antecedents that trigger the behaviour may be deeply personal and different for each participant, and it was considered unlikely that these would be shared in a group format. Individual sessions allowed the researcher to adapt and apply the techniques taught during the session to target the different needs of each participant. These sessions also ensured that each person would be heard and given equal attention, which is not always possible within group settings.

Chapter 2.2: Rationale for Techniques taught in the Psycho-educational Intervention Programme

The research literature and the three models that have been used to conceptualise compulsive shopping demonstrate that the main function the shopping behaviour serves is to regulate negative affects and improve self-esteem. The negative emotions associated with compulsive shopping seem to be the result of an inability to apply coping strategies to everyday life problems and/or an inability to challenge negative thought patterns about oneself or one's life situations.

Zeidner and Saklofske (1996) state that adaptive coping requires both task-focussed skills as well as emotion-focussed skills. In order for a person to be adaptive in a variety of problematic situations the person must have a repertoire of coping strategies as well as the ability to apply the strategy that best suits the context of the problem. The psycho-

educational intervention programme provides a wide variety of coping strategies and helps to teach effective 'matching' of the strategies to fit the context.

2.2.1 Coping Strategies: Approach and Avoidance

Holahan, Moos and Schaefer (1996) classified coping strategies into four main styles; *approach, avoidance, cognitive and behavioural.* The *approach* style refers to the person's orientation towards the stressor, in that the person approaches the problem and makes active efforts to solve it. The *avoidance* style involves the person avoiding the problem and focusing mainly on managing the emotions associated with that problem. Both approach and avoidance styles can use either *cognitive* or *behavioural* methods. A summary of these styles is given in the table below, taken from Holahan et al. (1996).

Table1: Four categories of coping strategies with eight associated coping subtypes.

Basic Coping Categories	Coping Subtypes
Cognitive Approach	Logical Analysis: "Did you think of different ways to deal with the problem?" Positive Reappraisal: "Did you think about how you were much better off than other people with similar problems?"
Behavioural Approach	Seeking Guidance and Support: "Did you talk with a friend about the problem?" Taking Problem Solving Action: 'Did you make a plan of action and follow it?"
Cognitive Avoidance	Cognitive Avoidance: "Did you try and forget the whole thing?" Resigned Acceptance: "Did you lose hope that things would ever be the same?"
Behavioural Avoidance	Seeking Alternative Rewards: "Did you get involved in new activities?" Emotional Discharge: "Did you yell and shout to let off steam?"

Compulsive shopping is an example of both cognitive and behavioural avoidance styles of coping. The cognitive avoidance is achieved by shifting one's attention away from the problem and instead placing it on to the immediate stimuli readily available in the context of shopping. The behavioural avoidance is demonstrated by seeking alternative rewards

in the shopping behaviour, relieving negative emotions through the positive interactions with sales staff, and rewarding oneself with purchases that enhance self-image (Dittmar et al., 1996).

The styles of coping employed can be strongly related to the person's emotional state. People who are depressed, have low self-esteem, low self-efficacy and/or lack of social support are more likely to use emotional and avoidance strategies in contrast to behavioural approach strategies such as problem solving and assertive action (Flett, Blankstein & Obertynski, 1996; Jex & Bliese, 1999; Jex & Elacqua, 1999; Zeidner & Saklofske, 1996.).

2.2.2 Personal and Social Coping Resources

Personal resources that enhance a person's ability to cope with stressful situations include a relatively stable personality and cognitive characteristics that shape the appraisal and coping process. Two of the main personality characteristics that facilitated approach style strategies listed by Holahan et al. (1996) were self-efficacy and optimism. Self-efficacy was defined earlier as an individual's beliefs regarding the likelihood that a particular course of action or behaviour can be carried out successfully (Jex & Bliese, 1999). People with high self-efficacy tend to approach challenging situations in an active and persistent style, whereas those with lower levels of self-efficacy are more likely to avoid such situations (Jex & Bliese, 1999). People who are generally optimistic tend to use problem-focused coping strategies whereas pessimistic people tend to prefer strategies based on mood regulation (Holahan et al., 1996).

Social support plays a very important role in coping strategies by providing emotional support that bolsters feelings of self-esteem and self-confidence as well as providing guidance in assessing threats and planning coping strategies (Holahan et al., 1996).

Chapter 2.3: Intervention Programme Content and Sequence

The psycho-educational intervention programme consisted of nine weekly sessions, a one-month maintenance programme and a follow-up session. The sessions were held weekly as this gave the participants time to consolidate the information and enabled them to practise the techniques taught in the previous session before building on this knowledge further, thus preventing the participants from becoming overwhelmed and enhancing their compliance. The rationale for the psychological tests used in the programme, the semi-structured interview and the types of coping strategies taught are outlined below in the order that they were taught. (The complete intervention manual is given in appendix 1)

2.3.1 Psychological Measures

The participants were asked to complete the following psychological tests and questionnaires: the COPE (Carver, Scheier & Weintraub, 1989), GHQ-12 (Johnston et al., 1995; Goldberg, 1992), Depression Anxiety Stress Scale (DASS); (Lovibond & Lovibond, 1995), Questionnaire on the perceived impact of buying behaviour (Lejoyeux et al., 1997) and a Compulsive Buying Scale (Faber & O'Guinn, 1992).

These tests were used as they reliably measured the areas of the participant's life generally associated with compulsive shopping. They measured levels of depression, anxiety and the degree to which the participants felt they were able to make decisions, levels of self-worth, sleeping patterns, their coping strategies for everyday life stressors and their shopping behaviour. A questionnaire investigating the perceived impact of compulsive shopping by a significant other was sent to a close friend or relative of the participant, in order to augment and validate the participants' self-evaluation. The validity and reliability of these tests is presented in the method section below.

The results of these tests identified the areas of the participant's lives that required intervention such as high anxiety, depression, and/or lack of coping skills, and aided in the development and application of the intervention programme. The results also provided solid baseline data that could be used to measure the participant's progress across all these domains.

2.3.2. Semi-structured Interview

The semi-structured interview was used to collect phenomenological data as well as demographic data and was based on the interview used in McElroy et al. (1994). This interview was an important part of the programme as it provided detailed information regarding the participants shopping behaviour and on other areas of interest that had not previously been covered in research literature. It was important to gather this information during the baseline period as it provided an excellent opportunity to establish a good rapport with the participants before moving into the teaching/intervention stage. The

interview also provided further information on shopping behaviour allowing modification of the techniques taught in the intervention programme prior to commencement.

2.3.3 Self-awareness and Self-monitoring

Goleman (1996) states that self-awareness is the ability to recognise, name and monitor ones' feelings and emotions as they happen. Understanding the cause of the emotion and the link between emotional experience and thoughts is also a key aspect in self-awareness. According to Goleman (1996), self-awareness is crucial to psychological insight and self-understanding and forms the cornerstone of emotional intelligence.

Elliot (1994) stressed the importance for the intervention of compulsive shopping to focus on gaining a functional analysis of the compulsive shopping behaviour, so that through such self-monitoring the antecedents of the behaviour could be addressed and the functional benefits served by compulsive shopping could be replaced by alternative more adaptive behaviours.

Self-awareness and self-monitoring were skills suggested by Scherhorn (1990) as necessary to change a persons compulsive behaviour. The person must gain an understanding of their behaviour and recognise themselves as the authors of their actions, rather than viewing their behaviour as the result of 'puzzling compulsions.' Gaining this understanding places the person in a more powerful position to make adaptive choices and employ alternative behaviours.

It is for these reasons that the skills of self-awareness and self-monitoring were introduced first in the psycho-educational intervention programme. During the baseline period the participants kept daily diaries recording what happened prior to the shopping experience (e.g., fight with their daughter) as well as their thoughts and emotions prior, during and after the compulsive shop. This self-monitoring task is similar to that used in Wolf and Crowner's (1992) study applying a cognitive-behavioural intervention to the problem of binge eating, a problem that has similar antecedents and motivations to compulsive shopping (McElroy et al., 1995). The participants continued keeping these diaries for the duration of the programme as a means of aiding self-awareness and self-monitoring, while providing the researcher with a means of measuring their improvement.

It could be argued, that although the participants were gaining the skills of self-awareness and self-monitoring and an understanding of their shopping behaviour during the baseline period, this did not effect their shopping frequency, as they had not yet been taught to face their problems and apply adaptive strategies. They were therefore likely to continue shopping as normal during this baseline period.

2.3.4 Cognitive Restructuring

Cognitive restructuring training was included in the intervention programme and was taught during the first intervention session. The literature is very clear that compulsive shopping is generally comorbid with anxiety, depression and mood related disorders (Black et al., 1997; Christenson et al., 1994; Fishbain, 1994; McElroy et al., 1994). The

literature also supports and confirms the merits of cognitive restructuring in alleviating both anxiety and depression (Burns, 1992; Goleman, 1996; Martin & Birnbrauer, 1996; McGraw, 1999; Rehm, Kaslow & Rabin, 1987; Suinn, 1990; Watts, 1992). Cognitive restructuring was also proven to be effective in alleviating the symptoms of bulimia, which as discussed earlier with regards to the theoretical models shares commonalties with the problematic behaviour of compulsive shopping (Baumeister & Heatherton, 1996; Kettlewell, 1992; Thackaway et al., 1993). For these reasons the technique of cognitive restructuring was taught to help the participants alleviate these negative emotions commonly experienced. Cognitive restructuring can also improve feelings of self-efficacy and optimism (Burns, 1992) and therefore improve the likelihood of the participants persevering with the intervention and employing more 'approach style' coping strategies (Jex & Bliese, 1999; Zeidner & Saklofske, 1996).

It was considered important that the participants learn to recognise and challenge negative thoughts early on in the intervention, as this may help to build their self-esteem and assist them to feel more in control of their emotions, thus providing a solid foundation on which to teach other coping strategies. If cognitive restructuring is not taught early on in the programme, negative thoughts and perceptions may undermine the intervention and hinder the participants' progress.

2.3.5 Active Planning

It has been reported that having a perception that there are too many things to do, or that the task is too large or too hard to manage will result in feelings of depression, helplessness and anxiety and will give rise to avoidance strategies (Burns, 1992).

The skill of active planning involves organising one's day, by listing the things that one needs to get done and estimating time taken for each task. It involves breaking daunting tasks down into smaller more manageable ones, and recognising each of these smaller tasks as a compete task in itself. Active planning then involves the person taking assertive action to complete the tasks listed for that day. If they do not complete all the tasks, it is not detrimental provided that the majority of the tasks are completed or that they did something else equally constructive with their time.

The ability to organise one's day and achieve the tasks set out for that day builds a feeling of self-efficacy and competence. Listing the tasks also requires the person to face their tasks and take action to complete them rather than avoid them.

2.3.6 Problem Solving

It has been stated in the literature that compulsive buying behaviour is generally preceded by negative emotions such as tension, and anxiety (Christenson et al., 1994). These emotions are said to be the result of an inability to cope with stress, frustrations and unpleasant situations (Scherhorn, 1990). Depression and anxiety have been related to the inability to solve problems that arise in everyday life, and this leads to the adoption of

avoidance style coping strategies (d'Zurilla & Goldfried, 1971; Zeidner & Saklofske, 1996).

To improve effectiveness of the psycho-educational intervention programme it is important that training is focused on dealing with the earliest antecedent evident in compulsive shopping which in this case is inability to solve problems (Baumeister & Heatherton, 1991). Teaching problem solving skills and how to apply these skills effectively should reduce the frequency and intensity of negative emotions experienced in reaction to everyday life stressors. The ability to problem solve will also improve the person's feelings of competence, self-esteem and sense of control over external events, thereby reducing the likelihood of avoidance strategies such as compulsive shopping being performed in times of stress.

2.3.7 Budget Advice

The psycho-educational intervention programme included professional budget advice due to the literature reporting that most compulsive shopper's sought help only once their debts had become unmanageable (Christenson et al., 1994). Since this was a self-identified programme for compulsive shopping a session on budget advice seemed more than justified. Receiving professional help with their finances provided the participants with practical ways to help face and order yet another aspect of their lives that is likely to be causing them a degree of anxiety and stress. In the cases where money was held jointly, spouses and partners of the participants were invited and encouraged to come to this session. Having someone close to the participant take part could also aid the

effectiveness of the intervention by showing an active interest and giving the participant social support (Holahan et al., 1996).

Budget advice was given at this stage in the intervention as it gave time for the participants to consolidate the techniques already taught and continue practising them without the pressure of learning new techniques.

2.3.8 Emotional Writing

Emotional experience is very central to the behaviour of compulsive shopping, especially negative emotional states. Effective intervention should therefore teach ways to deal with these emotions. It has been shown in a number of studies that writing about personal events (especially traumatic, upsetting and stressful ones) can have a beneficial effect both psychologically and physically (Pennebaker, 1993). The act of writing about a traumatic event helps individuals to translate the event into language. Once encoded linguistically, individuals can more readily gain insight, find meaning or attain closure from the experience (Pennebaker, 1993).

Emotional writing is an adaptive skill to deal with negative emotions that can not be curbed by problem solving or cognitive restructuring. Emotional writing is also beneficial if the person does not detect the antecedent in time to apply the problem solving strategy and as a result becomes overwhelmed with feelings of anxiety or depression. This negative emotion would normally lead to compulsive shopping, however, emotional writing provides an alternative that has been proven through research to have positive

psychological and physiological effects (Pennebaker, 1993). This writing also provides a safe outlet for the expression of emotions, whereas in the past compulsive shoppers may have avoided or suppressed such emotions as was suggested in Scherhorn's (1990) theory of *distorted autonomy*. The merits of emotional writing is also supported by Telch's (1997) research, that reported improvements in women with binge-eating disorder after being solely taught emotion regulation techniques without any cognitive-behavioural therapy.

Another benefit of this coping strategy is that it does not require anyone else to read the writing in order for the person to feel better, gain understanding and closure. It is likely that people who shop compulsively do not have the social support to talk about their emotions and problems which leads them to use avoidance strategies (Holahan et al., 1996). The writing task provides an alternative way of expressing oneself and obtaining answers or closure when social support is lacking.

2.3.9 Relaxation Training

Relaxation training was taught in order to provide the participants with another skill that they could use to help relieve anxiety and tension as these emotional states are commonly reported in compulsive shopping literature (Christenson et al., 1994; Elliot, 1994). Relaxation training involves being aware of the sensations of tension and relaxation in the different muscle groups of the body, therefore aiding the further development of self-awareness (Bernstein & Borkovek, 1973; Jacobson, 1938; Wolpe, 1958; Suinn, 1990). This training was given immediately after the emotional writing task and therefore helped

the participant unwind and become relaxed before the end of the session as the writing task can be upsetting and stressful.

2.3.10 Sleeping Techniques

Sleep disturbance and insomnia are particularly common in people with stress-related disorders and depression (Seligman, 1990). Compulsive shopping is often comorbid with such disorders and therefore it seemed appropriate to teach techniques to help the participants overcome sleep disturbance. The techniques taught focussed on separating the cues for falling asleep from the cues for other activities, thereby strengthening the bed as a cue for sleep and to weaken it as a cue for other activities (e.g., reading, thinking) that may interfere with sleep (Blampied & France, 1993; Bootzin, 1977).

Although this aspect of the participant's lives is probably not directly linked to their shopping behaviour the intervention programme sought to take a holistic approach and to provide a wide variety of skills to help relieve the symptoms of compulsive shopping and improve quality of life for the participants.

2.3.11 Assertiveness Training

Assertiveness training builds on and pulls together the skills learnt earlier in the programme (self-awareness, self-monitoring, cognitive restructuring and problem solving). The training teaches the person to be aware of what they are feeling, why they are feeling that way and what it is that they want to change or make happen. The participants were taught ways to honestly state these feelings and wants to others without

denying the rights of others to be respected (Bishop, 1993; Dawley & Wenrich, 1976; Kaufman & Raphael, 1990). Being assertive requires the person to take responsibility for their life and their life choices. This is a significant change from the pre-intervention thinking where the shopping behaviour was 'puzzling' or the result of 'irresistible' impulses. By accepting responsibility for their thoughts, emotions and behaviour the person is placed in a position to make decisions and take action to change aspects of their lives with which they are dissatisfied. This approach-style coping strategy is likely to reduce feelings of anxiety, frustration and depression thereby reducing the likelihood of escape or avoidance behaviours like compulsive shopping (Mattick, 1996).

2.3.12 Maintenance Plan

Zeidner and Saklofske (1996) emphasise the importance of having a repertoire of coping strategies that include both 'task-focussed' and 'emotion-focused' strategies and also having the ability to chose and apply the most appropriate strategy to the situation. The participants were given practice at matching the coping strategy to the situation during the maintenance session.

The maintenance session required the participants and the researcher to work together to identify possible high-risk situations that may arise in the future and that could potentially lead to compulsive shopping behaviour if not dealt with effectively. The participants take one of these high-risk situations and decide which strategies they would apply to that situation and explain to the researcher why they chose those particular strategies and the types of results they would expect. Forming a maintenance plan in this

fashion should reduce the likelihood of relapse. As the participants complete the programme feeling confident that they have consolidated the strategies taught and practised applying them to real life situations and have developed a plan of action for these possible high-risk situations should they occur in the future. A similar session was used by Smith, Marcus and Kaye (1991) in a cognitive-treatment programme designed for obese and binge eaters and proved to be effective.

Chapter Three

Method

Chapter 3: Method

3.1 Participants

The participants were self-identified compulsive shoppers who responded to an advertisement placed once a week for three consecutive weeks in the public notice section of a local Christchurch newspaper (Appendix 3). The advertisement invited volunteers to take part in a free programme designed to help alleviate the symptoms of compulsive shopping. The participants identified themselves as compulsive shoppers by matching themselves against some of the broad criteria set out by McElroy et al. (1994) included in the advertisement.

Thirteen women and two men responded to the paper advertisement. Twelve were able to be contacted and more information about the programme was sent out in the post (Appendix 1, p. 159). After the respondents had received the information sheets they were contacted to ascertain whether they were able to participate in the study, and to answer any questions or queries they may have had, and to organise a time for the first session.

Of the fifteen initial respondents six women agreed to join and commit to the programme. Following the second session one of the six participants was excluded from the study, as she did not meet the criteria of a compulsive shopper set out by McElroy et al. (1994).

3.2: Measurements

3.2.1 COPE

The COPE is a multidimensional coping inventory developed by Carver, Scheier, and Weintraub (1989) incorporating 15 conceptually distinct scales which were developed on theoretical grounds or chosen on the basis of previous research that demonstrated their role in facilitating or impeding adaptive coping in different contexts.

Adaptive Strategies	
Active Coping (1)	Taking action, and exerting effort to remove or circumvent the stressor.
Planning (2)	Thinking how to confront the stressor, planning one's active coping efforts.
Seeking Instrumental Support (3)	Seeking assistance, information, or advise about what to do.
Positive Reinterpretation and Growth (7)	Making the best of the situation by growing from it, or viewing it in a more favourable light.
Acceptance (9)	Accepting the fact that the stressful event has occurred and is real.
Likely Adaptive Strategies	
Seeking Emotional Support (4)	Includes getting sympathy or emotional support from another person.
Suppression of Competing Activities (5)	Suppressing attention to other activities in order to concentrate more completely on dealing with the stressor.
Turning to Religion (6)	Increasing engagement in religious activities
Restraint Coping (8)	Coping passively by holding back one's coping attempts until they can be of use.

Table2.1. The 10 COPE scales considered to be most adaptive (Carver et al., 1989). The actual number of the COPE scale strategy is given in brackets.

Maladaptive Strategies when Active Coping is Required	
Focus on Venting Emotions (10)	An increase in the awareness on one's emotional distress, and a concomitant tendency to discharge those feelings.
Denial (11)	An attempt to reject the reality of the stressful event.
Mental Disengagement (12)	Psychological disengagement from the goal with which the stressor is interfering, through day dreaming, sleeping or self-distraction.
Behavioural Disengagement (13)	Giving up, or withdrawing effort from, the attempt to gain the goal with which the stressor is interfering.
Alcohol and Drug Use (14)	Using alcohol and/or drugs to think about the stressful event less.

Table 2.2 The 5 COPE scales considered as *maladaptive strategies* when adaptive coping is required (Carver et al., 1989). The actual number of the COPE scale strategy is given in brackets.

The inventory consists of 60 statements that ask respondents to indicate the extent to which they make use of each coping response when they experience stressful events. Each scale has four items in the self-administered questionnaire, and the scores for each item range from 1 ('I don't do this at all') to 4 ('I do this a lot'). The scores for each scale range from 4 to16 indicating the extent to which each type of coping was used.

Scales 1, 2, 3, 7 and 9 (active planning, planning, seeking instrumental social support, positive reinterpretation and growth and acceptance) measure coping responses which are hypothesised to be adaptive in situations where active coping is associated with a good outcome. Scales 4, 5 and 8 (seeking emotional social support, suppression of competing activities and restraint coping) there is a less obvious link with active coping but these should also be adaptive (see table 2.1).

The internal consistency of the COPE scales was evaluated by Carver et al. (1989) and was found to be high, all scales exceeding 0.6 with the exception of mental disengagement (scale 12) which consists of a number of disparate items and is, therefore, less likely to be internally consistent. Test-retest reliabilities were evaluated and the results indicated that the coping tendencies measured by the COPE are reasonably stable (Weinman, Wright, & Johnston, 1995).

In this study the COPE was used to assess dispositional coping (typical responses to stressors) although it can also be used to assess situational coping i.e., responses to a specific situation during a specific time period. Carver et al. (1989) administered both the dispositional and situational versions of the COPE in order to examine the relationship between the subjects' general coping strategies and the situation-specific coping strategies. Patterns of dispositional and situational reports were found to be similar overall, although for the situational responses the subjects reported using fewer active coping skills i.e., less positive reinterpretation and growth, less turning to religion, and less mental disengagement, in dealing with specific stressors.

One of the goals of this research was to investigate the relationship between compulsive shopping, anxiety, depression and coping mechanisms and to discover which (if any) aspects of coping changed during the intervention.

3.2.2 The General Health Questionnaire (GHQ-12)

The General Health Questionnaire-12 (GHQ-12) designed by Goldberg (1992) is a abbreviated version of the well-validated General Health Questionnaire-60 (GHQ-60) (Johnston, Wright, & Weinman, 1995). The new shortened version has been found to be as valid and reliable as the original. The GHQ-12 was designed to detect non-psychotic psychiatric disorder in people in the community and in medical settings as well as measure the degree of disorder.

Each of the twelve items in the GHQ-12 asked whether the respondent had experienced a particular symptom or item of behaviour recently, for example 'have you recently been able to concentrate on whatever you are doing?' or 'have you recently lost much sleep over worry?' The responses are scored using a four point scale; 'less than usual', 'no more than usual', 'rather more than usual' or 'much more than usual'. The questionnaire may be scored in two ways. It can be scored so that responses score 0, 0, 1 and 1 respectively. This gives scores ranging from 0 to 12 and is useful in detecting cases. The other method uses Likert scoring, where responses score 0, 1, 2, and 3 respectively. This method gives scores ranging from 0 to 36 and is more useful for comparing the degree of disorder as it gives a less skewed distribution of scores.

The GHQ-12 was used to assess general health and feelings of efficacy of the participants and was also useful in highlighting problem areas in the participants' lives that could be incorporated into the intervention, such as loss of sleep due to worry, inability to make

decisions. These problems could be addressed during the intervention with anxiety coping strategies such as cognitive restructuring or problem solving techniques. The Likert scoring method was used as it was the degree of the disorder that was of interest and this scoring also helped compare changes in general well being before and after the intervention.

3.2.3 Depression Anxiety Stress Scale (DASS)

The Depression Anxiety Stress Scale (DASS); (Lovibond and Lovibond, 1995) is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. Each of the three DASS scales contains fourteen items, divided into sub-scales of two to five items with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty in relaxing, nervous arousal, and being easily upset or agitated and irritable or over-reactive and impatient behaviour (Lovibond & Lovibond, 1995). Subjects are asked to use a 4-point severity/frequency scale to rate the extent to which they have experienced each state over the past week. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

The DASS is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS is based is that differences

between the depression, the anxiety and the stress experienced by normal people and by those with clinical symptoms are essentially differences of degree. The DASS therefore has no direct implications for the allocation of patients to discrete diagnostic categories such as those used in formal diagnostic schemes (e.g. DSM-IV).

The scales of the DASS have been shown to have high internal consistency and yield meaningful discriminations in a variety of settings (Brown, Chorpita, Korotitsch, and Barlow, 1997). The DASS was used in the present study as depression, anxiety and stress are believed to be relevant to compulsive shopping (Christenson et al., 1994; McElroy et al., 1994). The DASS is also a useful inventory to assess changes in the participants' mood over time.

3.2.4 Semi-Structured Interview

The semi-structured interview used in this research was based on McElroy et al. (1994) who interviewed twenty compulsive buyers. The semi-structured interview (Appendix 1 p. 168) elicited demographic data, such as age, marriage status, number of dependent children, annual personal income. The interview focussed on phenomenological data information and included the age of onset, and the course of shopping behaviour and how it had developed and changed over time; shopping frequency and the types of items bought, the situations that lead to shopping, the shopping venue; the emotions that were felt prior to during and after a compulsive shop; whether shopping caused personal distress and the aspects that caused distress; help sought in the past and any current medication, including antidepressant or anxiety relieving medication.

The semi-structured interview was used in this research to gain a greater understanding of the participants' shopping behaviour and its relationship to their life history and circumstances, and to apply the intervention sessions to the participants' individual shopping characteristics. For example, the same cognitive restructuring technique was taught to all participants although for some cognitive distortions causing anxiety were targeted while for others cognitive distortions causing feelings of helplessness and depression were given more attention.

3.2.5 Questionnaire: Perceived Impact of Compulsive Shopping

The questionnaire of Perceived Impact of Compulsive Shopping was a modified version of the Questionnaire About Buying Behaviour designed by Lejoyeux and Ades's (1994) and Lejoyeux et al. (1997) to assess the buying impulses and the consequences of shopping behaviour. The modifications used in this present study involved changing the nineteen yes/no questions into a four point Likert scale (Appendix 2). The questions covered the main features of compulsive buying including urges to shop, emotions felt prior, during and after shopping, post-purchasing guilt and regret, consequences of shopping behaviour and avoidance strategies. A Likert scale was employed to allow more graded responding, rather than forcing all or nothing responses from the participants since that may result in over or under exaggeration of the impact of the shopping behaviour. A Likert scale also gave a greater understanding of the buying behaviour, by allowing the researcher to investigate the values for the different questions and also allowed key features or characteristics to be identified. The respondents answered all the

questions with either 1-Never, 2-Occasionally, 3-Regularly, or 4-Always, except the final question which required the respondent to give an estimate of the number of times their purchases had provoked a prolonged misunderstanding with family members or friends in the last six months.

Each participant was asked to nominate a significant other (a third party) who would also fill out this questionnaire based on how they perceived the participants buying behaviour and its impact on the participant. This was done to gain consistency measures between the scores of the participants and the scores of the third party.

3.2.6 Compulsive Buying Scale

The Compulsive Buying Scale was devised by Faber and O'Guinn (1992) to serve as a screening tool for compulsive shopping and consists of seven statements that are rated by respondents using a five point Likert scale. The questions were derived from discussions with compulsive shoppers, e.g., 'others would be horrified if they knew of my spending habits', as well as statements derived from theory, the researcher's expertise and other therapists. In these statements particular focus was given to the common features of impulse control disorders, e.g., feeling an urge to shop, increased anxiety prior to shopping, gratification during shopping followed by feelings of regret or depression afterwards.

A logistic regression analysis specified weightings for the seven statements that significantly contributed to distinguishing compulsive buyers from other consumers.

Therefore the respondent scores to the statements are evaluated using a scoring equation = -9.69 + (Q1a X .33) + (Q2a X .34) + (Q2b X .50) + (Q2c X .47) + (Q2d X .33) + (Q2e X .38) + (Q2f X .31). A score $\leq$ - 1.34 classified the respondent as a compulsive buyer (Faber & O'Guinn, 1992).

The Compulsive Buying Scale has high face validity and reasonably high criterion and construct validity. The reliability of this scale is also considered to at an acceptable level (Faber & O'Quinn, 1992).

The scale was specifically designed to screen for compulsive buying and was used in this research as a tool to help classify the respondents to the paper advertisement as compulsive shoppers and to help evaluate their progress at the completion of the intervention.

Chapter 4

Results

Chapter 4: Results

Chapter 4.1 Qualitative Results

The qualitative data presented below was synthesised from the information gathered in the tape-recorded semi-structured interviews as well as from the daily diary entries kept by the participants. Transcripts of the interviews were made from the tape recordings and then analysed with respect to the findings found in previous research (Elliot, 1994; McElroy et al., 1994; McElroy et al., 1995; Scherhorn, 1990). Likewise the daily diary entries were used to further confirm the emotional and behavioural experiences reported in the semi-structured interviews. The diaries also provided information on the antecedents and cognitions involved in compulsive shopping not previously included in the research literature and these were evaluated across participants and the consistent trends identified are discussed below.

4.1.1. Onset and Development

The participants began shopping in a compulsive way on average at age nineteen (onset ages ranged from seventeen to twenty-five years). The participants had been compulsive shoppers for an average of eighteen years (duration ranged from nine to twenty-three years).

4.1.2 Comorbid Disorders

Four of the five participants had sought help in the past for comorbid disorders, two for anxiety related disorders and two for depression and mood disorder. The two participants

with depression and mood disorders were on anti-depression medication prior to the intervention programme and for the entire duration of intervention and follow-up. One participant also struggled with gambling behaviour prior to and during the intervention programme.

4.1.3 Frequency and Duration of Shopping

Participants would shop compulsively on average two to three times a week. All participants reported that their time spent shopping varied (from 10 minutes to 8 hours) depending on the amount of time they had to spend.

4.1.4 Planned or Spontaneous?

In general compulsive shopping was spontaneous or not planned. Participants would generally decide to go shopping on the day. The participants had an idea of the shops they wanted to shop in, although they were often unsure of what they were going to buy. *"Yesterday I went out for a storage bin and came back with a dress...I generally know what shops I buy from, so I will go into all the other shops first. So if I can't find anything in those shops I can go back to my favourite shops because I know that I can find something in there to buy."*

Items on sale would usually persuade four of the five participants to make a purchase because they found bargains hard to resist. *"I went into Farmers and I saw these teddy bear tins that were on sale and we don't need them we have plenty of tins and things at home but because they were on sale I bought them...I also bought a chopping board and*

the only reason I bought it was because it was on sale." Buying items because they were on sale was not the case for all of the participants. *"I do try and buy bargains, but if it is a choice between this dress and that dress it is not a question of money. The question is do I like this dress or do I like that one?"*

4.1.5 Type of Purchases

The majority of the purchases were appearance related, involving clothes either for themselves or their children, shoes, jewellery, accessories, toys for their children, or things for the home such as furniture, dinner sets and appliances. Other items included books, CDs, stationary, groceries and sports equipment. One participant spent the majority of her money on presents for her family and friends as her way of showing appreciation and love. *"But that is what you do when you love someone, you want to buy them things"*

4.1.6 Phases in Purchasing & Buying in Excess

Most of the participants would go through phases with the items they bought, like a phase where they would just buy things for the house, or clothing for themselves, or just particular items of clothing which were often bought to excess. *"I go through phases where I will buy jewellery...last summer I tried hard to find the perfect sunglasses and bought five pairs...I also went through a phase with jackets and bought six jackets...At one stage I had 12 dinner sets and then I realised that was a bit excessive so I started giving them away...I went through a phase with togs and bought 6 pairs...I have about 100 or so items of*

baby clothes that I have bought just in case I have another baby...I have about 80 to 100 pairs of shoes and they are not the shoes I wear, I collect them I don't throw them out, I just add to them."

4.1.7 Purchases: Kept, Returned, Hidden or Given Away

Some participants would hold onto their purchases while others would return or give the items away when they no longer wanted them. *"People say that I am generous but it is usually because I don't want it anymore. If I decided that I don't want something I think what is the point of hanging on to it. And in fact rather than sell it to someone I don't know, I would rather give it to someone I know and like."*

Whether the participant kept the items or not seemed dependent on how much sentimental value was attached to the item. *"Everything I have bought I have bought for a reason so there is sentimental value with everything. I bought that for that particular occasion, good or bad it is a memory in itself...I've been moving into my flat this week and it has been horrific packing things into boxes. I go to work and say "I hate this my life is in boxes"...But none of my clothes were put into boxes...they didn't even come off the hangers, I just lifted them off and put them in the car...I remember how much every item was, where I bought it from, whether the sales assistant was nice or not."*

Interestingly, this type of clear recollection of purchased items illustrated in the quote above seems to be somewhat characteristic of compulsive shoppers. In that

all participants could state where they bought a particular item, how much they had paid for it, whether the sales assistant was pleasant or not.

The participants who would hide some of their purchases generally did so because the money they spent was perceived (by the participants and their partners) to be their 'partners', or because a close friend or family member was trying to help them spend less.

4.1.8 Personal Distress

All five participants reported that compulsive shopping was causing some level of personal distress including financial difficulties, strains on marital and personal relationships, anxiety and frustration due to lack of savings. When questioned during the early stages of the intervention as to why they thought they shopped compulsively the majority of participants reported being 'puzzled' by their behaviour because they recognised that their spending was unnecessary. Two participants were aware that their shopping behaviour was similar to that of one of their parents and suggested that perhaps they had learnt the behaviour, although they did not report an understanding of why they themselves performed the behaviour.

4.1.9 Attention Seeking and Revenge

In a few of the participants the act of shopping and the spending of money was performed in attempt to gain attention from a spouse. The spending also provided a way of hurting

their spouse with the debt, and gave them opportunity to express their anger in a covert way. Similar findings were reported in Faber (1992).

4.1.10 Emotional Experience

The emotions experienced prior, during and after a compulsive shop were consistent in four of the five participants, the emotional states are discussed below.

Prior to Shopping

Negative emotions prior to shopping were commonly experienced although the types of emotion were different for each participant. The negative emotions experienced included anxiety, depression, anger, tension, frustration, and boredom. However there was one participant who when depressed did not want to go shopping or even leave the house, but would go shopping when she felt good about herself and her life.

During the Shopping Experience

The emotions experienced while shopping were positive: happy, excited, secure and feeling pleased with one-self. The shopping experience seemed to relieve tension and stress, with the emphasis on the act of shopping rather than on the buying per se.

" I really enjoy it, it keeps me sane...it is my stress relief, I can just wonder around and buy nothing...spend hours and hours window-shopping...I don't actually think it is the buying, that you want to buy stuff. It's sort of at that particular point in time I need this.'

Euphoric mood was also reported during the shopping experience.

"When I've been shopping I am floating, sky high. I could skip along anywhere...it can last for the rest of the day...I am completely overwhelmed when I am in the shopping centre it is like the whole world belongs to me and I can do anything I want in there and I can buy whatever I like and money is not a problem."

Despite this euphoric mood, feelings of anxiety would sometimes accompany the buying process and this seemed to be related to whether or not the purchases could be afforded.

After the Shopping Experience

The positive emotions gained through the buying experience were often replaced with negative ones, such as regret and guilt. *"Afterwards I feel really bad, I feel like saying O.K that was nice, I enjoyed it but you can have it all back now."*

The negative emotions seem dependent on whether they had enough money to spend on the items, and whether they were accountable to anyone.

"My mother use to shop like me and now she is accountable to my father. So she sees what I do as a problem because one day I will be accountable to someone. But at the moment it is my money to do with as I please...I have times when I come home and say, 'Well I didn't really need that, I shouldn't have bought that, oh well'."

4.1.11 Self-esteem

No direct measures of self-esteem were taken during the research although through comments made by the participants it seems that shopping had a positive effect on self-esteem and improved their perceptions of themselves and others perceptions of them. *"I think it is a self-esteem thing, I feel better about myself when I am neat and tidy...I don't like to look like a solo mum its important that my kids are dressed well...I think the reason I shop is out of inadequacy."*

Positive interaction with the sales staff also played an important role. *"The fact that the sales assistants know who I am is half the reason I go back. And depending on your mood the assistants will ask 'Now how are you today?...Oh that looks wonderful...Now last time you were here you were doing...how is that going?"*

4.1.11 Cognitive and Behavioural Escape

For some the shopping behaviour provided the person with both a physical and a cognitive escape from their life, as was illustrated in a number of the participants' comments. *"The house is a mess, and I have so much work to do and I can't be bothered doing it so I go out shopping...sometimes I get caught up in it and perhaps might be late to pick up my son from school. Or I'll be on my way to visit someone and arrive about 2 hours later because I am shopping, or I'll get so busy shopping I forget to feed my baby and I think oh she hasn't been fed and it has been five hours.'*

4.1.12 Modelling and Childhood

The research revealed that in the majority of cases the participants had family members who also shopped compulsively, whether they were the participants' parents who shopped compulsively or whether the participants' sons and/or daughters were beginning to behave in a similar way. *"I think I get it from my family, well in particular my father. I think he has been a depressed person and he would buy things to cheer himself up. He has spent thousands and thousands of dollars on things usually cars and motors and things. And it was quite upsetting for mum because quite often they would have $4000 left on the mortgage and almost pay it off and then dad goes out and puts a truck on the mortgage another $20,000."*

Some participants explained their shopping behaviour as a way of compensating for what they felt they missed out on in childhood. *"Growing up we had six children and we didn't get many toys I was always jealous of my cousin who would have thirty or forty dolls and I would have one. And I felt that I had missed out not having all these things so I felt I didn't want my kids to miss out. And now I am just completely overboard in fact I rooms of toys. I am overcompensating for my childhood."*

4.1.13 Cleanliness and Order

The participants quite often reported excessive cleanliness and order in their houses. Some would refer to their houses as a mess, but within the mess was meticulous order. *"All my cupboards and drawers are so neat and tidy and really well organised. In my*

clothes drawer all my T-shirts are folded in a certain way...my bookshelves are all in order and I go to great lengths to make sure everything is tidy...when I do housework I am so thorough, I pull out everything and make sure I vacuum all the floor so clean that you could eat of it...I am very ordered, You wouldn't think to look, because I live in a constant mess, but everything has its spot, whether it is on the floor in a pile it will be on the third layer of that pile. So I know where everything is, so it is ordered chaos, very ordered chaos."

4.1.14 Fear of Missing Out

Participants reported making purchases because they were afraid they would 'miss out' if they waited. *"Quite often I will buy things that are not on sale because I think if I wait until the sale I might not get it...I will buy more than I need because we might run out of it and I may not be able to get to the shops...I buy things now because I have the money, because later on I may not have the money and I'll want it...Even now I regret not making some purchases. I've gone back to the shop to get the thing that I wanted and it was not there and I feel like I've missed out. Even when realistically I think I won't have another child, I can't resist buying cute baby clothes because if I ever did have another child those clothes may not be around...I probably have too many lay-bys but I think I want to get that and put it on lay-by in case they sell out."*

Buying out of fear of missing out was a consistent finding across all participants. This type of behaviour is an illustration of avoidance responding. Avoidance

responding involves responding in the present (i.e., buying) to prevent or avoid an event happening in the future (i.e., missing out on the purchase). It is also an illustration of the cognitive distortion described by Burns (1992) as *the fortune teller error*, in that a person anticipates that things will turn out badly, and presume that this prediction is an already-established fact.

4.1.15 Payment

The majority of the participants paid for their purchases by cash or Eftpos (Electronic Funds Transfer at Point of Sale). Two participants had store cards (which allow you to buy from the store on credit) and one of those participants had a credit card. Three participants did not possess any credit or store cards. Some would use lay-by to make their purchases *"I have actually got 7 lay-bys at the moment and I want to get a couple more."* Some participants reported borrowing off friends and family members *"I would owe people money and instead of paying them back I would buy more things which would make me feel guilty."* One participant would only buy items that she could pay for herself by cash.

4.1.16 Conclusion

The consistent characteristics of compulsive shopping revealed from the analysis of the semi-structured interviews and the daily diary entries are as follows. Compulsive shopping effects predominantly women and develops on average at age nineteen although is not generally recognised as problematic until the behaviour begins to

result in personal distress (e.g., financial debt, vocational and marital problems) generally twenty years or so later.

Compulsive shopping was found to be comorbid with anxiety and depression disorders as well as gambling problems. The participants generally had a parent who also shopped compulsively and/or their own children had begun to display similar behaviour, suggesting that compulsive shopping could be a learnt response to negative affect developed through the act of modelling.

The participants would shop compulsively two or three times a week, the duration of time spent shopping varied from 10 minutes to 8 hours depending on the amount of time the participant had available. Shopping was generally unplanned, the purchases were normally appearance related (clothes for themselves and their children, jewellery, accessories) and also included such things as gifts, food and furnishings for the home. The participants reported buying these items in phases and often in excess (e.g., 12 dinner sets, 100 pairs of shoes and 5 pairs of sunglasses). Whether the items were kept, hidden or returned seemed dependent on how much sentimental value was attached to the item as well as the amount of accountability the participant had. Participants who were married with joint bank accounts were more likely to return or hide items than the participants who were single and had their own separate accounts.

The majority of the participants (80%) reported negative emotions prior to compulsive shopping including depression, anxiety, anger, frustration and boredom. All participants reported positive emotions while shopping including feeling happy, excited, secure, pleased with oneself and relief from tension. Comments made by the participants reflect feelings of euphoria *'I am completely overwhelmed...it is like the whole world belongs to me and I can do anything I want and buy what ever I like and money is not a problem.'* Despite this euphoric mood anxiety was reported to accompany the buying process in cases where the purchases being made could not be afforded. The positive emotions were reportedly related to the shopping experience as a whole rather than the sole act of purchasing goods. The positive emotions brought about by shopping were short lived and often replaced with feelings of regret and guilt. These negative emotions seemed dependant on whether the purchases could be afforded and whether the participants were accountable to anyone.

The act of shopping had positive effects on the participants self-esteem, improving the perceptions of themselves through the purchasing of appearance enhancing items and through the positive affirmation received from sales staff. Shopping also provided negative reinforcement through the cognitive and behavioural escape from life stressors. Another example of an escape and avoidance strategy was evident in the purchasing of items out of fear of 'missing out' purchases were made in order to avoid the negative consequence of not being able to buy the product in the future.

4.2: Quantitative Results

4.2.1 Demographic Data

The demographic data of the five participants who completed the psycho-educational intervention program are presented in Table 2.3 All five participants were female of European ethnicity. Participants 1, 2, 3 and 4 were between the ages of 36 and 42 years. Participant 5 was the youngest at 26 years.

Participants 1 and 4 were married, Participant 3 was divorced and Participant 2 was in the process of getting divorced at the time of the intervention. Participant 5 was single and never married. Participants 1, 3 and 5 had an annual income between $20,000 to $40,000. Participant 2 had an annual income between $10,000 and $20,000, and Participant 4 had an annual income between $40,000 and $60,000.

All participants (except Participant 5) had children (range: 1 - 3) and the ages of the children across the participants ranged from 7 months to 23 years.

Participant 1 was the only participant who had credit cards. Participant 1 and 3 both had store cards that allowed them to buy from a certain store on credit.

Four of the participants had sought help in the past for medical problems related to psychological well being. Participants 2 and 4 had sought treatment for depression and were on antidepressant medication for the duration of the intervention programme. Participants 1 and 3 had received treatment for anxiety related disorders. Participant 5 had not sought any help in the past for any psychological disorders.

Participant	Sex	Age	Ethnicity	Income Bracket	Marital Status	Dependent Children	Age of Children	Credit Cards	Store Cards	Prior Medical Problems
1	F	40	European	B	Married	2	20 & 23yrs	2	1	Panic Attacks
2	F	36	European	A	Married/Separated	2	7mths & 9yrs	0	0	Depression
3	F	42	European	B	Divorced	3	9, 14 & 19yrs	0	1	Anxiety
4	F	40	European	C	Married	2	7 & 9yrs	0	0	Depression
5	F	26	European	B	Single	0	--	0	0	None

Income Bracket: **A**= $10,000 –20,000 **B** = $20,000-40,000 **C** = $40,000- 60,000

Table 2.3 Demographic data of the five participants that completed the psycho-educational intervention programme.

4.2.2 Psychological Tests and Questionnaire Results

4.2.2.1 Compulsive Buying Scale

Participant	Pre-Intervention	Post-Intervention
1	-4.32	-1.74
2	-3.56	-0.32
3	-3.24	-1.04
4	-4.25	-0.55
5	-6.65	+1.55

Table 3. Pre and Post-Intervention Scores for the Compulsive Buying Scale. A score $\leq$ - 1.34 classifies a compulsive shopper (Faber and O'Guinn, 1992).

The participants were classified as compulsive shoppers if their score was $\leq$ - 1.34 on the Compulsive Buying Scale. Table 3 gives the scores for the five participants all of whom scored less than –1.34 at pre-intervention and were therefore classified as compulsive shoppers. At the one-month follow-up the post-intervention scores for all participants (except Participant 5) were greater than –1.34 and therefore no longer met the criteria for compulsive shoppers. Participant 5's score increased from –4.32 at pre-intervention to –1.74 at post-intervention and although this later score has increased it was not greater than –1.34, which is required to no longer meet the criterion for a compulsive shopper.

4.2.2.2 Compulsive Shopping Questionnaire

Participant	Participant Scores		Significant Other Scores	
	Pre-Intervention	Post-Intervention	Pre-Intervention	Post-Intervention
1	42	28	44	28
2	30	22	--	--
3	32	23	--	--
4	42	24	--	--
5	42	24	43	--
	M = 37.6 SD=6.05	*M*=24.2 SD=2.28		

Table 4 – Pre and Post-Intervention scores for the Questionnaire on Perceived Impact on Buying Behaviour.

The questionnaire on Perceived Impact of Buying Behaviour uses a four point Likert scale. If the compulsive shopping questions applied to their behaviour 'always' or 'regularly' they scored higher than if the responses were 'occasionally' or 'never'. Table 4 shows the results from the Perceived Impact Questionnaire. At pre-intervention the mean was 37.6 (SD 6.05) and the post-intervention mean was 24.2 (SD 2.28). Four out of the five participants nominated a significant other to complete the same questionnaire on their behalf, however only two completed the questionnaire at pre-intervention and only one completed the questionnaire at follow-up.

4.2.2.3 General Health Questionnaire (GHQ-12)

	Participant Scores	
Participant	**Pre-Intervention**	**Post-Intervention**
1	20	6
2	18	7
3	16	9
4	21	21
5	23	2
	M=19.6 SD=2.7	*M*=9 SD=7.2

Table 5. Participants' responses to the General Health Questionnaire (GHQ-12).

The results on the GHQ-12 are shown in Table 5. Four of the participants' scores had improved greatly at post-intervention, and one participants' score remained the same. The mean pre-intervention score was 19.6 (SD 2.7) and the post-intervention score was 9 (SD 7.2).

4.2.2.4 Depression Anxiety Scale (DASS)

	Participants Scores				General Population Scores N= 717	
	Pre-Intervention		Post-Intervention			
DASS Scales	Mean	SD	Mean	SD	Mean	SD
Depression	18.4	9.8	2.8	1.9	7.2	6.6
Anxiety	14.8	12.9	6.4	2.8	5.2	4.8
Stress	25	11.3	9.2	1.9	10.5	6.9

* General population scores are taken from Lovibond and Lovibond (1995).

Table 6. Mean pre and post-intervention scores on the Depression Anxiety Stress Scale (DASS). Mean and standard deviations of a general population sample included for a comparison.

Table 6 shows that the mean pre-intervention scores of the participants in the three DASS scales, depression, anxiety and stress were nearly three times higher (18.4, 14.8, and 25 respectively) than the mean scores for the general population (7.2, 5.2 and 10.9 respectively). At post-intervention the mean scores of the participants' had significantly decreased. The mean score for depression post-intervention was 2.8, which was lower than the mean score for the general population (7.2). The participants' mean score for the anxiety scale at post intervention was 6.4 which was close to the general population mean for anxiety (5.2). The stress scale which had the highest mean out of the DASS scales at pre-intervention of 25 decreased to 9.2 at post intervention which was below the mean recorded in the general population sample (10.5).

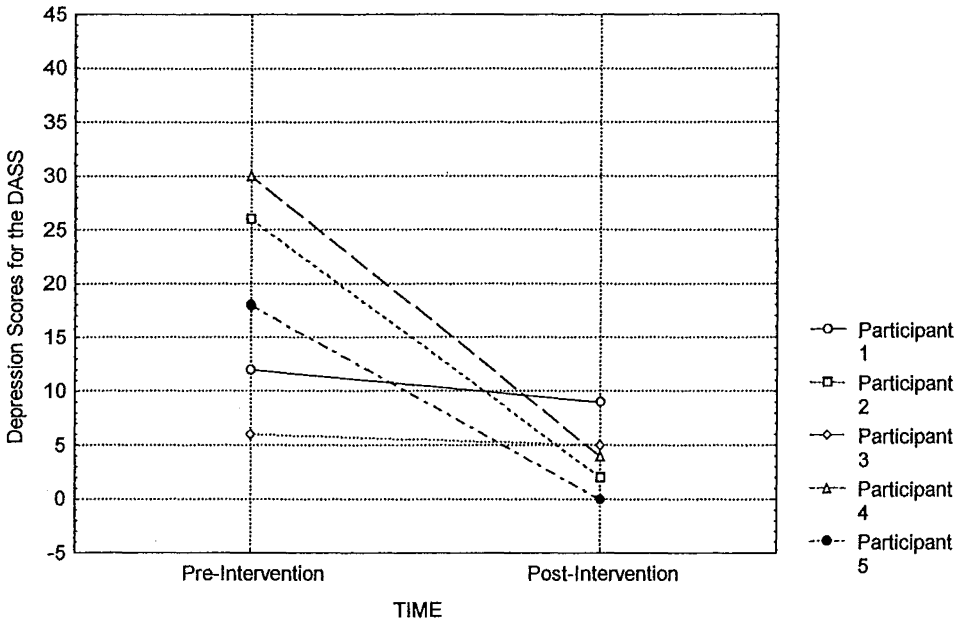

Fig-2. Individual scores on the Depression scale of the DASS pre and post-intervention

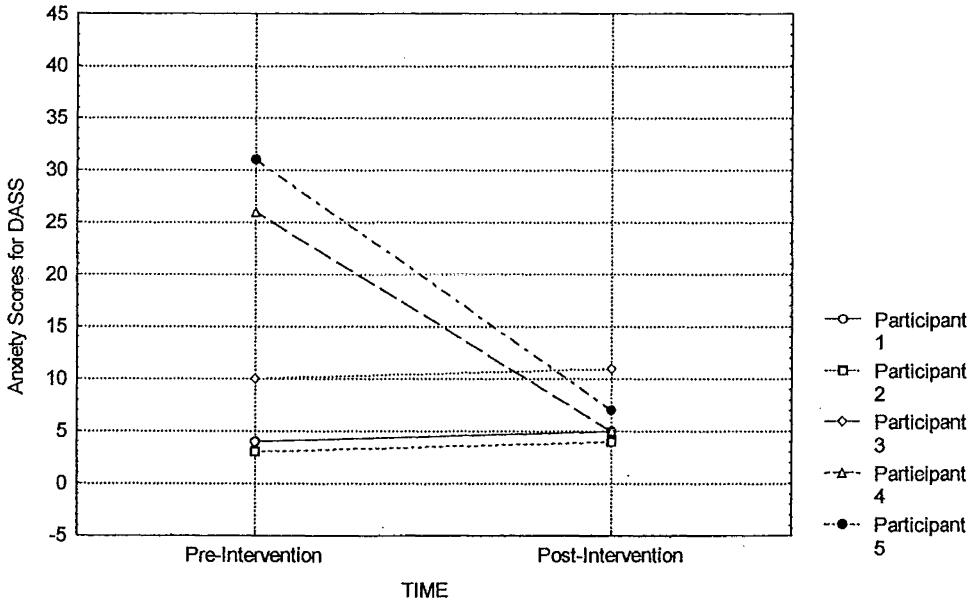

Fig 3. Individual scores on the Anxiety scale of the DASS pre and post-intervention.

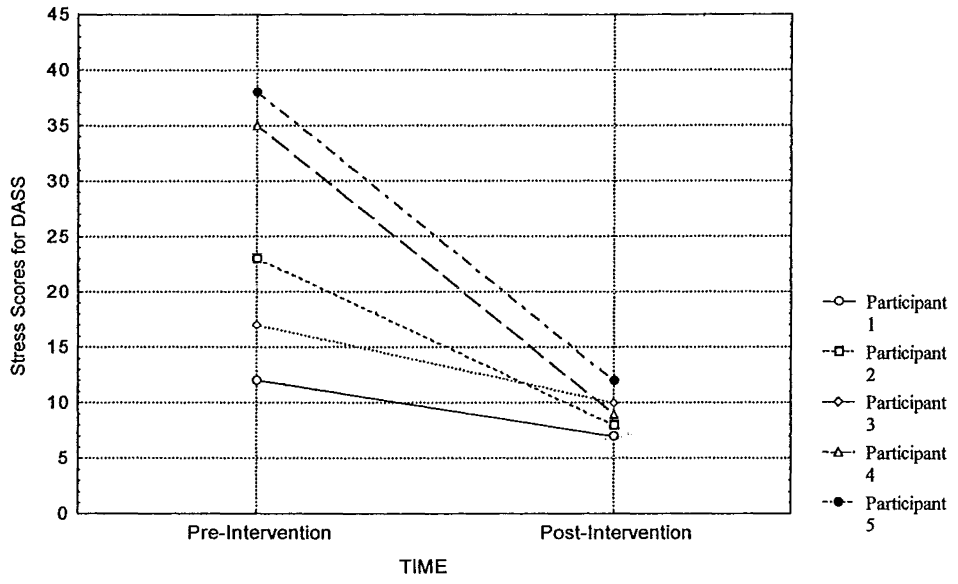

Fig 4. Individual scores on the stress scale of the DASS pre and post-intervention.

Figure 2 shows the pre and post-intervention scores of the participants on the DASS scale of Depression. Participants 2, 4 and 5 had pre-intervention scores of 26, 30 and 18 respectively that were much higher than the corresponding general population score. These scores reduced at post-intervention to 2, 4 and 0 respectively. The scores of Participants 1 and 3 were similar to that of the general population, and these scores remained relatively stable at post-intervention. Participants 2, 4 and 5 had high pre-intervention scores, however at post-intervention their scores were lower than those of Participants 1 and 3.

Figure 3 displays the individual pre and post-intervention scores of the participants for the DASS scale of Anxiety and shows that Participant 3, 4 and 5 had higher anxiety scores at pre-intervention than the mean score of the general population. The scores of Participants 4 and 5 decreased substantially post-intervention whereas the score of Participant 3 had increased slightly post-intervention. The scores of Participants 1 and

2 were similar to that of the general population mean at pre and post-intervention, although both these participants' scores had increased slightly post-intervention.

Figure 4 displays the individual pre and post-intervention scores of the five participants on the DASS scale of Stress and the graph shows that the scores of all participants at pre-intervention were higher than that of the general population mean (10.05 – Table 6) and at post-intervention all these scores had decreased substantially with a range of 7 to 12. The scores on the stress scale for Participants 4 and 5, decreased from to 35 and 38 to 9 and 12 at post-intervention.

Examination of figures 2, 3 and 4 shows that Participants 2, 4 and 5 generally scored higher than the other participants on the DASS scales of depression, anxiety and stress. All participants who scored high on these scales at pre-intervention had substantially decreased scores at post-intervention and attained scores that resembled the means for the general population.

COPE Categories	Participants Scores Pre-Intervention. Mean	Std	Post-Intervention Mean	Std	General Population Scores N= 1030 Mean	Std
1. **Active Coping	8.6	2.7	11	2.0	11.9	2.3
2. **Planning	9.6	2.8	12.2	1.1	12.6	2.7
3. **Seeking Instrumental Support	11.2	3.3	12.8	2.6	9.9	2.4
4. *Seeking Emotional Support	11.4	3.9	12.6	3.1	10.2	2.5
5. *Suppression of Competing Activities	8.8	3.7	9.2	0.8	11.5	2.9
6. *Turning to Religion	9.4	4.2	10.6	4.3	11	3.5
7. **Positive Reinterpretation and Growth	9.2	2.3	11.4	1.8	12.4	2.4
8. *Restrain Coping	7.2	3.8	8.6	3	11.8	2.6
9. **Acceptance	10	2.5	11.6	2.6	8.8	4.1
10. °Focus on Venting Emotions	10.6	3.8	9.8	2.7	10.2	3.1
11. °Denial	4.8	1.1	5.2	0.8	6.1	2.4
12. °Mental Disengagement	10.8	2.8	7.8	1.5	6.1	2.1
13. °Behavioural Disengagement	8	1.4	5.4	1.1	9.7	2.5
14. °Alcohol and Drug Use	6.8	4.4	5	1.7	--	--
15. Humour	6.6	2	7.2	2.2	--	--

KEY

** Adaptive

* Likely to be Adaptive

° Maladaptive when active coping is needed.

Table 7. Mean and standard deviation scores for the participants for each 15 COPE categories pre and post intervention. Means and standard deviations from a sample from the general population are included as a comparison. (Comparison scores were taken from Carver, Scheier and Weintraub (1989). The range of possible values is 4-16.

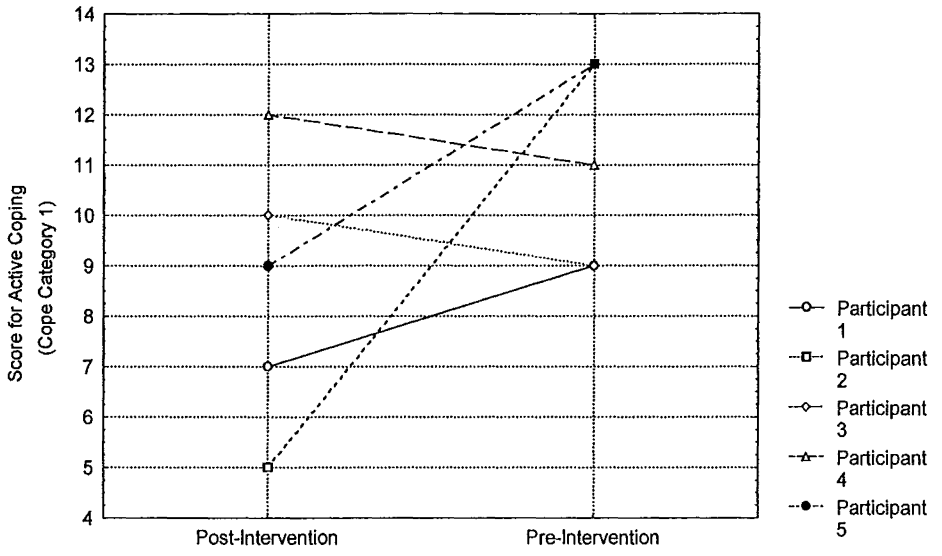

Fig 5. Participants' individual scores pre and post-intervention for the COPE category Active Planning (Category 1).

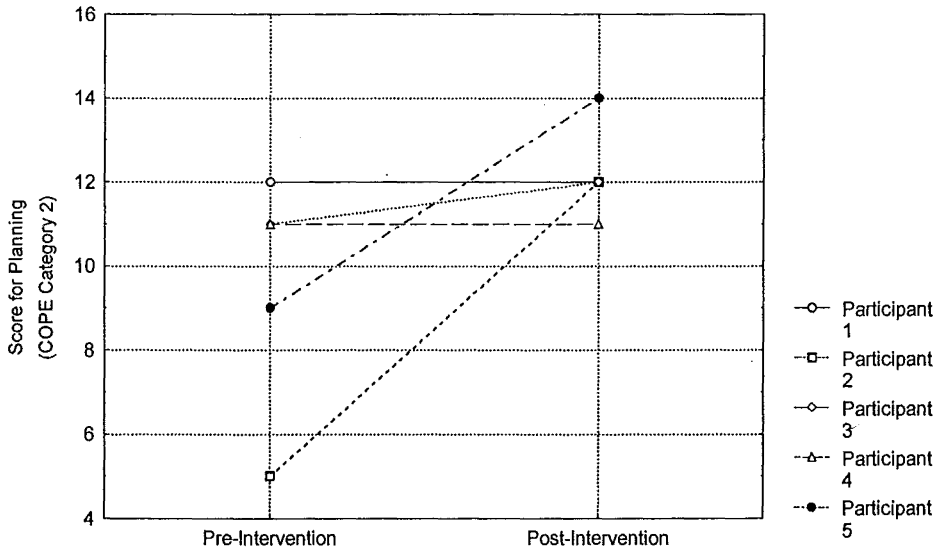

Fig 6. Participants' individual scores pre and post-intervention for the COPE category Planning (Category 2).

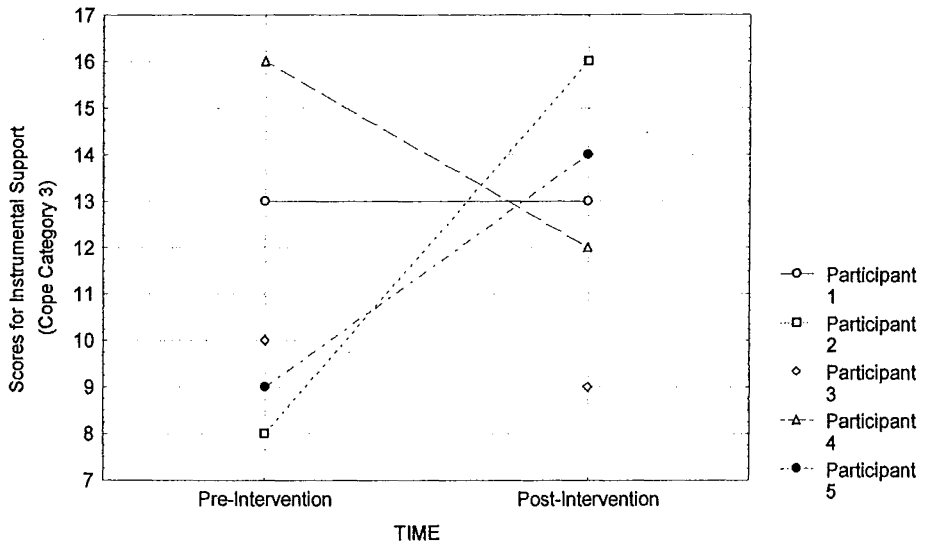

Fig 7. Participants' individual scores pre and post-intervention for the COPE category Seeking Instrumental Support (Category 3).

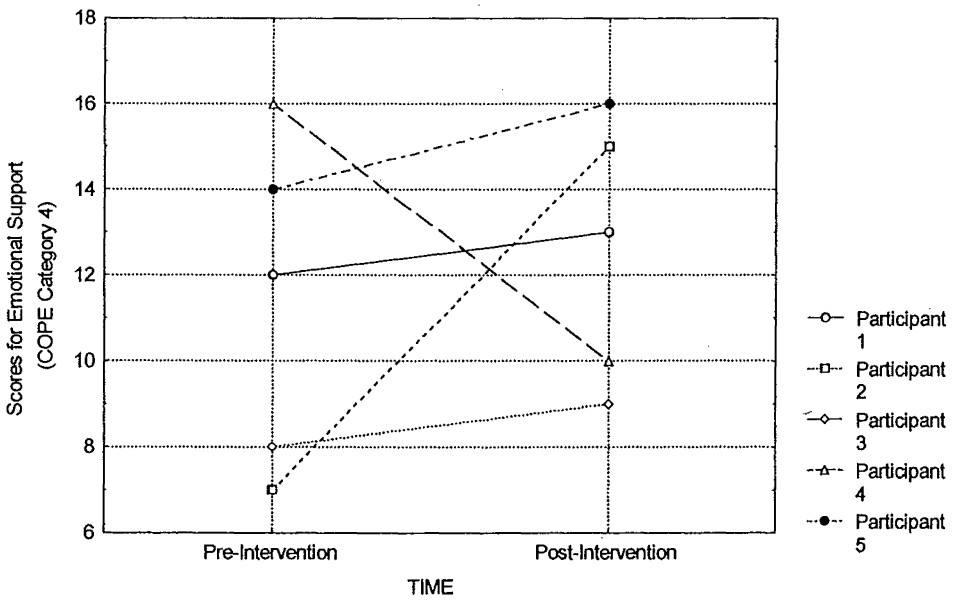

Fig 8. Participants' individual scores pre and post-intervention for the COPE category Seeking Emotional Support (Category 4).

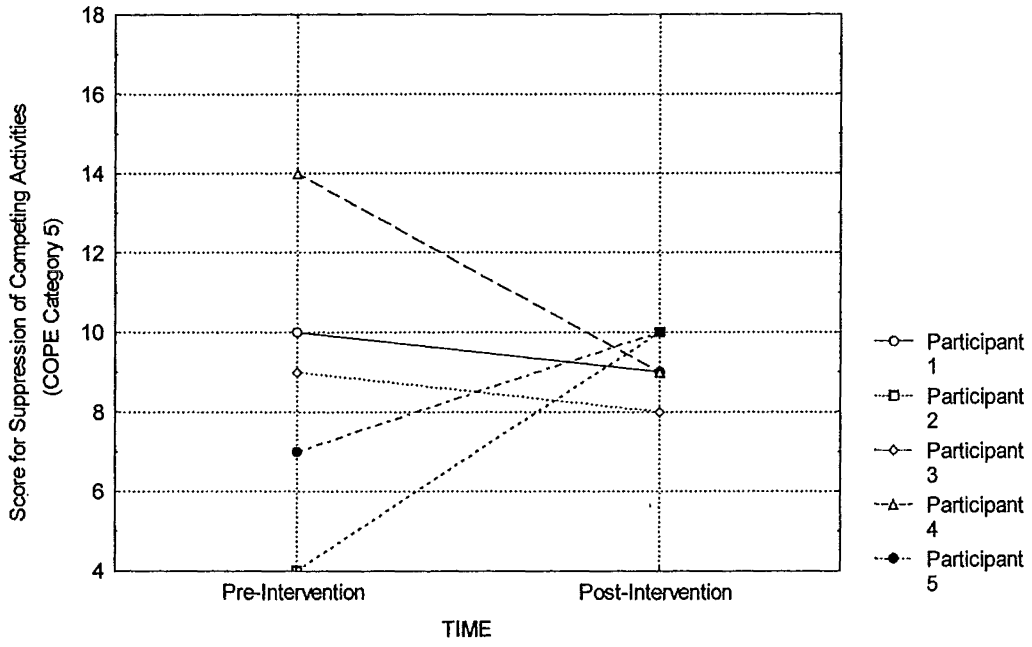

Fig 9. Participants' Individual scores pre and post intervention for the COPE category Suppression of Competing Activities (Category 5).

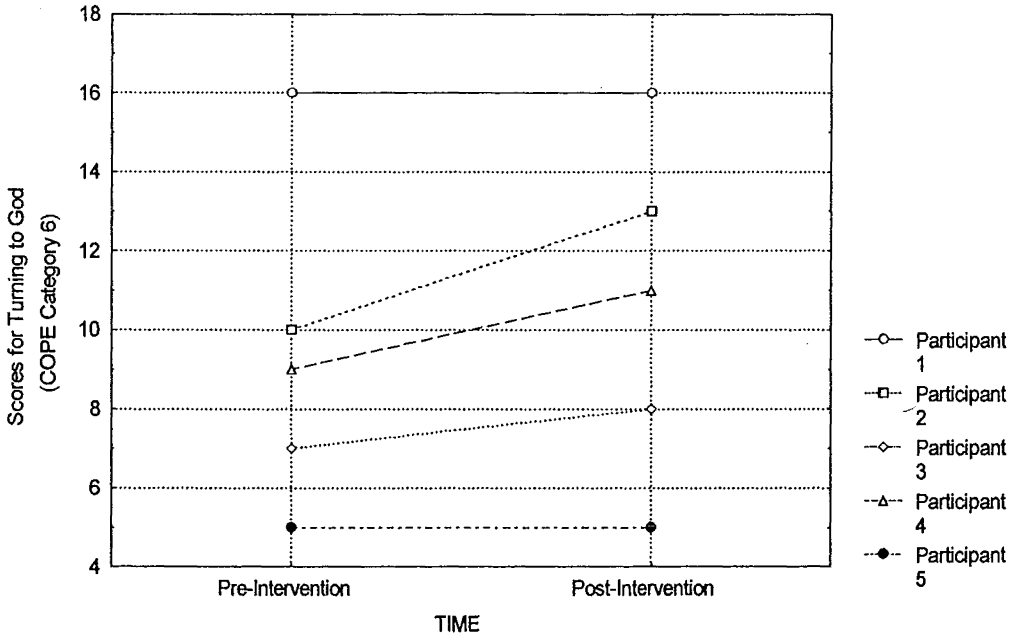

Fig 10. Participants' individual scores pre and post intervention for the COPE category Turning to God (Category 6).

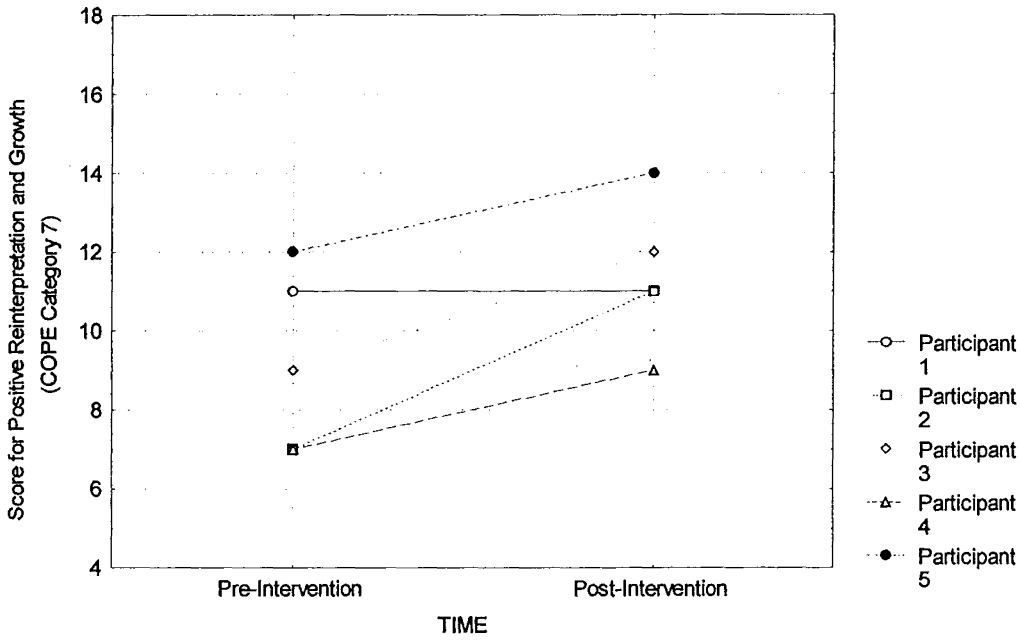

Fig 11. Participants' individual scores pre and post intervention for the COPE category Positive Reinterpretation and Growth (Category 7).

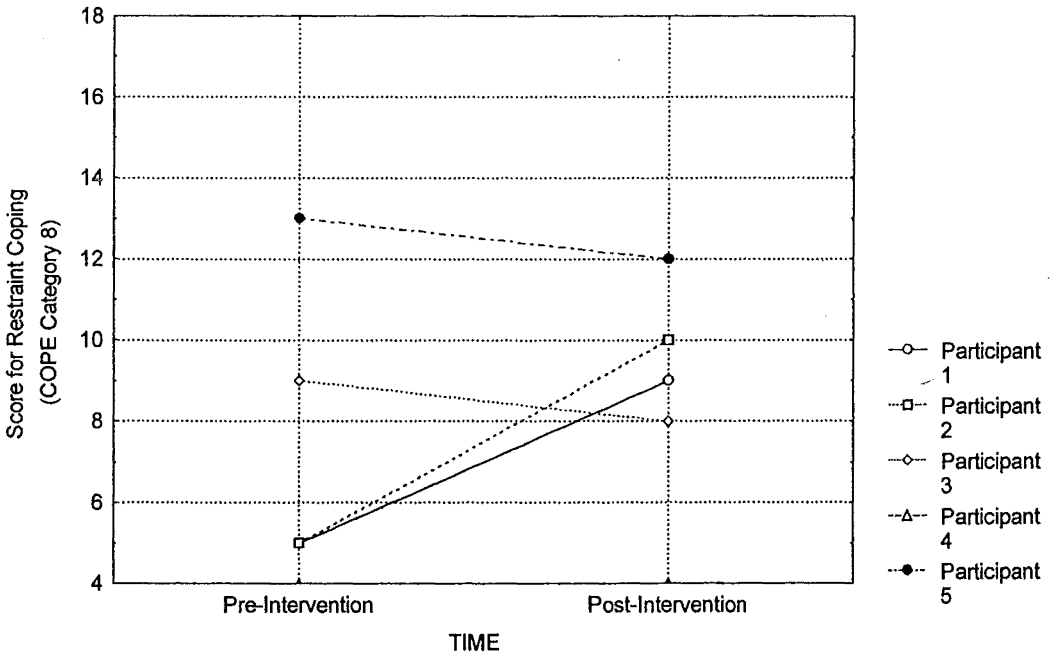

Fig 12. Participants' individual scores pre and post-intervention for the COPE category Restraint Coping (Category 8).

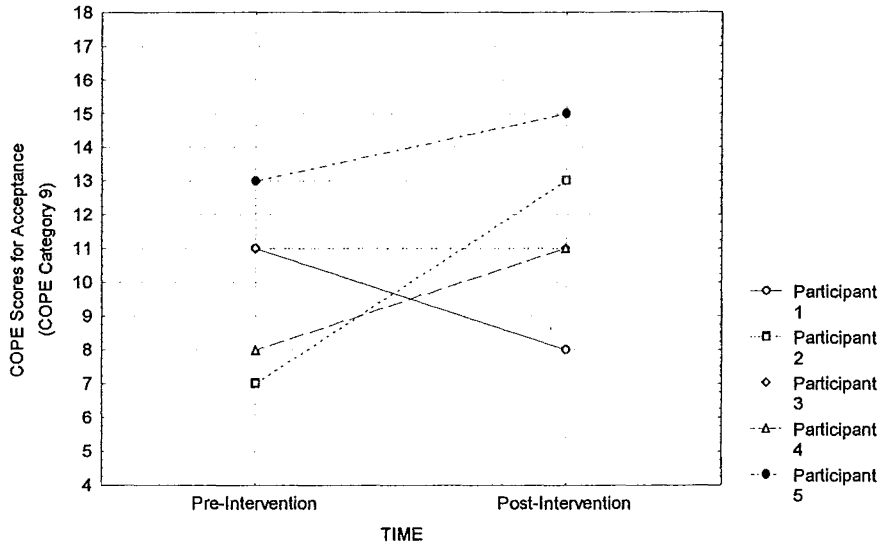

Fig 13. Participants' individual scores pre and post-intervention for the COPE category Accpetance (category 9).

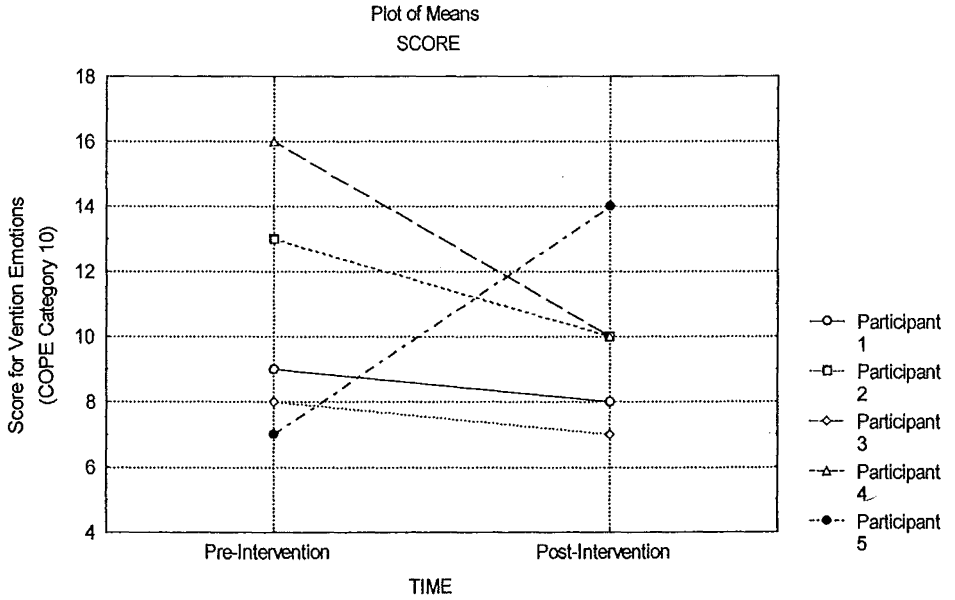

Fig 14. Participants' individual scores pre and post-intervention for the COPE category Venting of Emotions (Category 10).

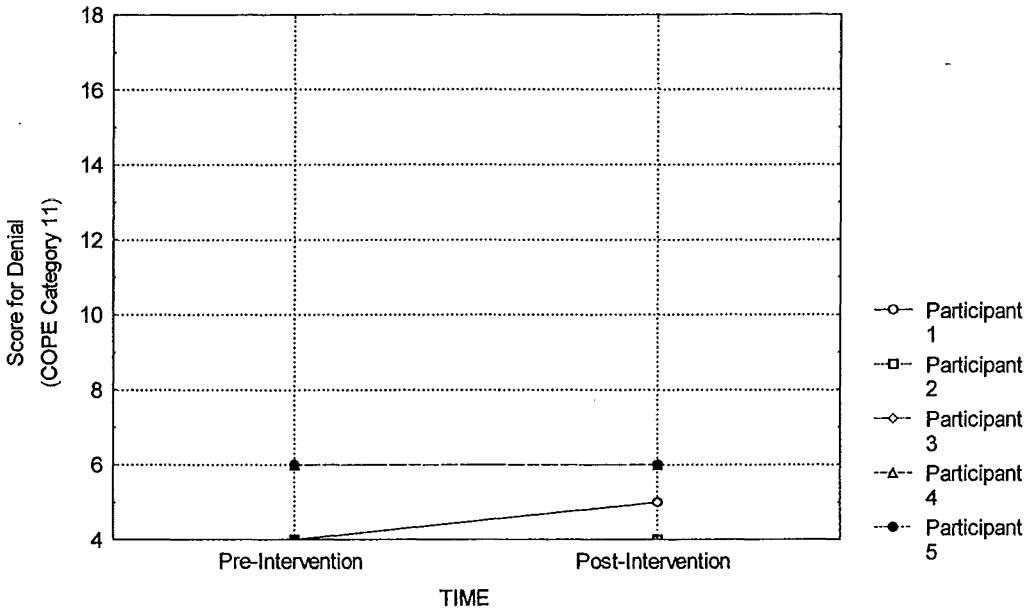

Fig 15. Participants' individual scores pre and post-intervention for the COPE category Deniel (Category 11).

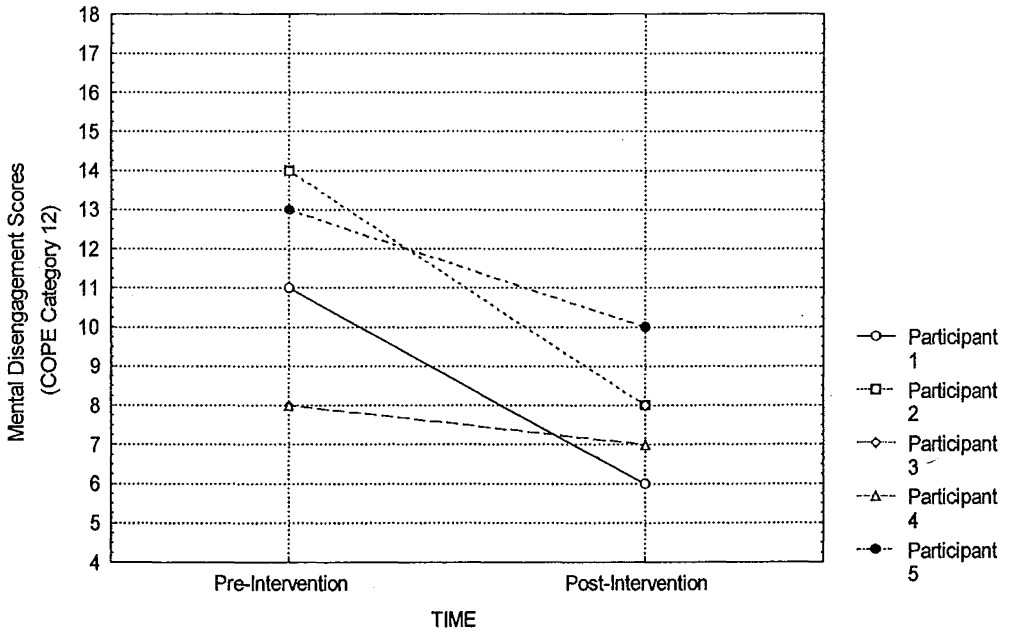

Fig 16. Participants' individual scores pre and post-intervention for the COPE category Mental Disengagement (Category 12).

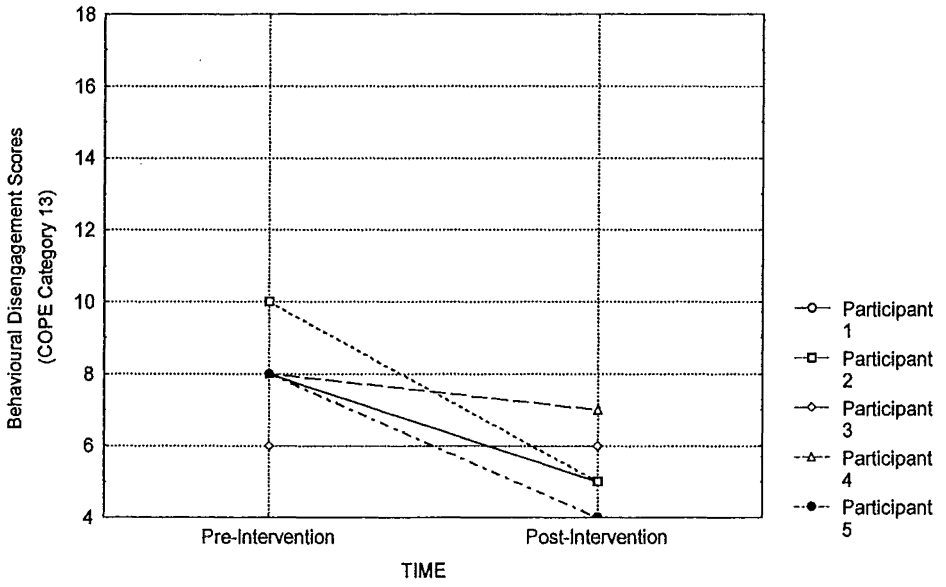

Fig 17. Participants' individual scores pre and post-intervention for the COPE Behavioural Disengagement (Category 13).

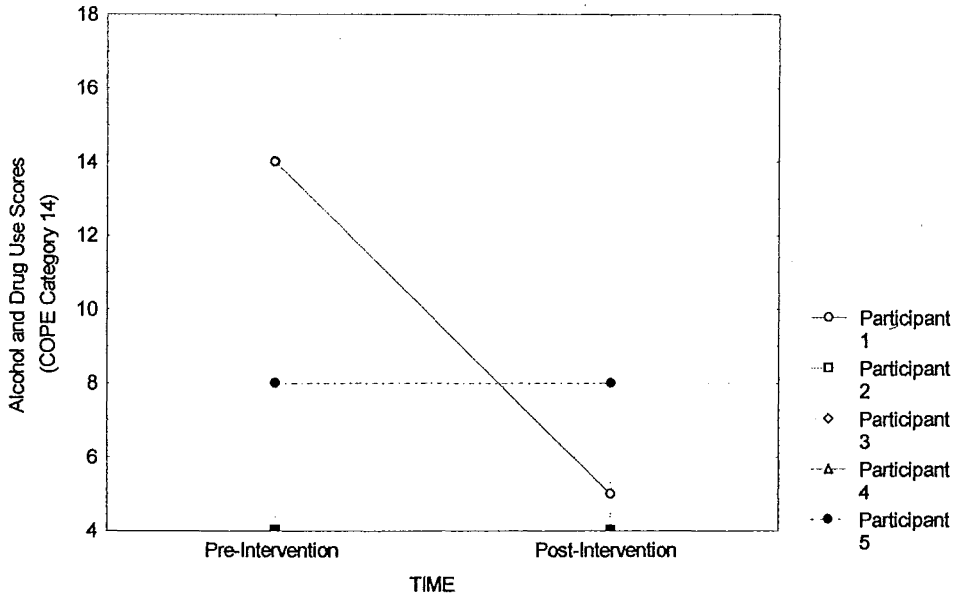

Fig 18. Participants' individual scores pre and post-intervention for the COPE category Alcohol and Drug Use (Category 14).

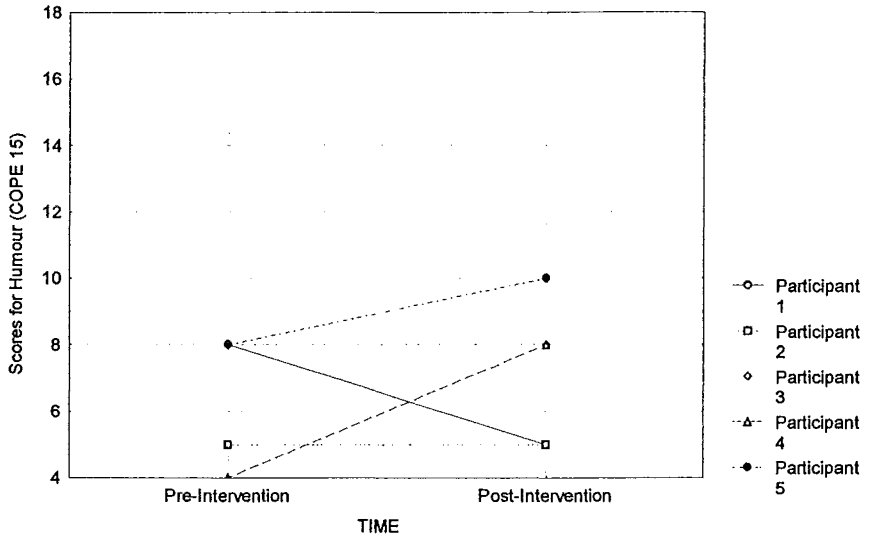

Fig 19. Participants' individual scores pre and post-intervention for the COPE category Humour (Category 15).

4.2.2.4 COPE Results

Table 7 displays the mean and standard deviation scores for the participants for each of the 15 COPE categories at pre and post-intervention. Means and standard deviations taken from a sample of the general population are also included as a comparison (Carver et al., 1989).

Adaptive Coping Scales

Active Planning

The active planning scores of Participants 1, 2 and 5 all increased post-intervention, from 7 to 9, 5 to 13 and 9 to 13 respectively (see figure 5). The scores for participants 3 and 4 declined slightly at post-intervention to 9 and 11.

The mean score of the participants for active planning at pre-intervention was 8.6 (SD 2.7) this increased to 11 (SD 2) at post-intervention, which is close to the general population mean of 11.9 (SD 2.3).

Planning

The planning scores of Participants 2, 3 and 5 scores increased at post-intervention, from 5 to 12, 11 to 12 and 9 to 14 respectively (see figure 6). Participant 1 scored 12 pre and post-intervention, Participant 4 scored 11 pre and post-intervention.

The mean pre-intervention score for the adaptive coping strategy of planning was 9.6 (SD 2.8) and this increased to a score of 12.2 (SD 1.1) at post-intervention, close to the mean score of 12.6 (SD 2.7) gained from the general population sample.

Instrumental Support

The instrumental support scores of Participants 2 and 5 increased at post intervention from 8 to 16 and 9 to 14 respectively (see figure 7). Participant 1 scored 13 at both pre and post-intervention, and the scores of Participants 3 and 4 both declined at post-intervention from 10 to 9 and from 16 to 12 respectively.

At pre-intervention the participants' means for seeking instrumental support was 11.2 (SD 3.3) and at post-intervention this had increased to 12.8 (SD 2.6). Both the pre and post-intervention means of the participants were higher than the mean value of 9.9 (SD 22.4) for the general population.

Positive Reinterpretation and Growth

The positive reinterpretation and growth scores for the participants are displayed in Figure 11. The scores of Participants 2, 3, 4 and 5 increased at post intervention from 9 to 12, 7 to 10, 7 to 9 and 12 to 14 respectively. Participant 1 scored 11 at both pre and post-intervention.

The mean pre-intervention score for this positive reinterpretation was 9.2 (SD 2.3) and at post-intervention this had increased to 11.4 (SD 1.8), however the mean post-intervention score was still lower than the general population mean of 12.4 (SD 2.4).

Acceptance

The acceptance scores for Participants 2, 4 and 5 increased at post-intervention from 7 to 13, 8 to 11 and 13 to 15 respectively (see figure 13). The score of Participant 1 decreased from 11 to 8, and Participant 3 scored 11 at both pre and post-intervention.

The mean pre-intervention score for acceptance was 10 (SD 2.5) and this increased to 11.6 (SD 2.6) at post-intervention, both these mean scores are higher than the general population mean of 8.8 (SD 4.1).

Relatively Adaptive Strategies

Seeking Emotional Support

The scores for emotional support are displayed in figure 8. Participants 1, 2, 3 and 5 had all increased at post-intervention from 12 to 13, 7 to 15, 8 to 9 and 14 to 16 respectively. The post-intervention emotional support score for participant 3 decreased from 16 to 10.

The mean score for seeking emotional support increased from 11.4 (SD 3.9) to 12.6 (SD 3.1), both of which are higher than the mean score for the general population of 10.2 (SD 2.5).

Suppression of Competing Activities

The suppression of competing activities scores of Participants 2 and 5 increased at post-intervention from 4 to 10 and from 7 to 10 respectively (see figure 9). The scores of Participants 1, 3 and 4 decreased at post-intervention from 10 to 9, 9 to 8 and 14 to 9.

The mean score for suppression of competing activities increased from 8.8 (SD 3.7) to 9.2 (SD 0.8), although the post intervention mean was still lower than the general population mean of 11.5 (SD 2.9).

Restraint Coping

The restrain coping scores displayed in figure 12 show that the scores of Participants 1 and 2 increased from 5 to 9 and from 5 to 10 respectively. The scores of Participants 3 and 5 decreased at post-intervention from 9 to 8 and 13 to 12 respectively. Participant 4 scored 4 at both pre and post-intervention.

The mean score for restraint coping increased from 7.2 (SD 3.8) at pre-intervention to 8.6 (SD 3.0) at post-intervention, both these means are lower than the mean for the general population of 11.8 (SD 2.6).

Turning to Religion

The scores for turning to God for the Participants 2, 3 and 4 increased at post intervention from 10 to 13, 7 to 8 and 9 to 11 respectively (see figure 10). Participant 1 scored 16 and Participant 5 scored 4 at both pre and post-intervention.

The mean score for turning to religion increased from 9.4 (SD 4.2) to 10.6 (SD 4.3) at post intervention which is relatively close to the general population mean of 11 (SD 3.5).

Maladaptive Coping Strategies

Venting Emotions

The scores for venting emotions for Participants 1, 2, 3 and 4 decreased at post-intervention from 9 to 10, 13 to 10, 8 to 7, and 16 to 10 (see figure 14). The score of Participant 5 increased from 7 to 14 at post-intervention.

The mean score for focussing on venting emotions decreased from 10.6 (SD 3.8) at pre-intervention to 9.8 (SD 2.7) at post-intervention, which is below the general population mean of 10.2 (SD 3.1).

Denial

The denial scores of the participants at both pre and post-intervention were lower than the general population mean of 6.1 (see figure 15). The score of Participant 1 increased from 4 to 5 at post-intervention. The scores of Participant 2, 4 and 5 remained the same at pre and post-intervention, they scored 4, 6 and 6 respectively. Participant 1 increased from 4 to 5 at post-intervention.

The mean score at pre-intervention was 4.8 (SD 1.1) for denial and at post-intervention this increased to 5.2 (SD 0.8) which is below the general population mean of 6.1 (SD

2.4). Although there was an increase in the mean at post-intervention, the mean was still very low considering the lowest mean score possible for any of these COPE strategies is 4.

Mental Disengagement

The mental disengagement scores for Participants 1, 2, 4 and 5 all decreased at post-intervention from 11 to 6, 14 to 8, 8 to 7 and 13 to 10 respectively (see figure 16). Participant 3 scored 8 at both pre and post-intervention.

The mean pre and post-intervention scores for mental disengagement decreased from 10.8 (SD 2.8) to 7.8 (SD 1.5), although the post-intervention score was still higher than the general population mean of 6.1 (SD 2.1).

Behavioural Disengagement

The behavioural disengagement scores for Participants 1, 2, 4 and 5 decreased at post-intervention from 8 to 5, 10 to 5, 8 to 7 and 8 to 4 respectively (see figure 17). The score of Participant 3 remained unchanged at 6 at post-intervention.

Behavioural disengagement decreased from a mean of 8 (SD 1.4) at pre-intervention to 5.4 (SD 1.1) at post-intervention. Both these scores are lower than the general population mean of 9.7 (SD 2.5).

Alcohol and Drug Use

The scores for alcohol and drug use remained unchanged at post-intervention for Participants 2, 3, 4 and 5 (see figure 18). Participants 2, 3 and 4 scored 4 and Participant 5 scored 8 at both pre and post-intervention. The score of Participant 1 score decreased from 14 at pre-intervention to 5 at post-intervention.

The mean score for alcohol and drug use was 6.8 (SD 4.4) pre-intervention and this decreased to 5 (SD 1.7) post-intervention.

Humour

The scores for humour for Participants 2 and 3 remained unchanged at post-intervention and scored 5 and 8 respectively (see figure 19). The scores of Participants 4 and 5 increased at post intervention from 4 to 8 and 8 to 10 respectively. The score of Participant 1 decreased from 8 to 5 at post-intervention.

The results of the humour scale show that the participants' means increased at post-intervention from 6.6 (SD 2.0) to 7.2 (SD 2.2). There is no general population data available to compare these means.

Summary

The results from the COPE show an increase in the participants scores for the 'Adaptive Strategies' and 'Relatively Adaptive Strategies' from pre to post intervention. Whereas

the participants scores for 'Maladaptive Strategies' all decreased from pre to post-intervention.

4.2.3 Compulsive shopping Frequency Graphs

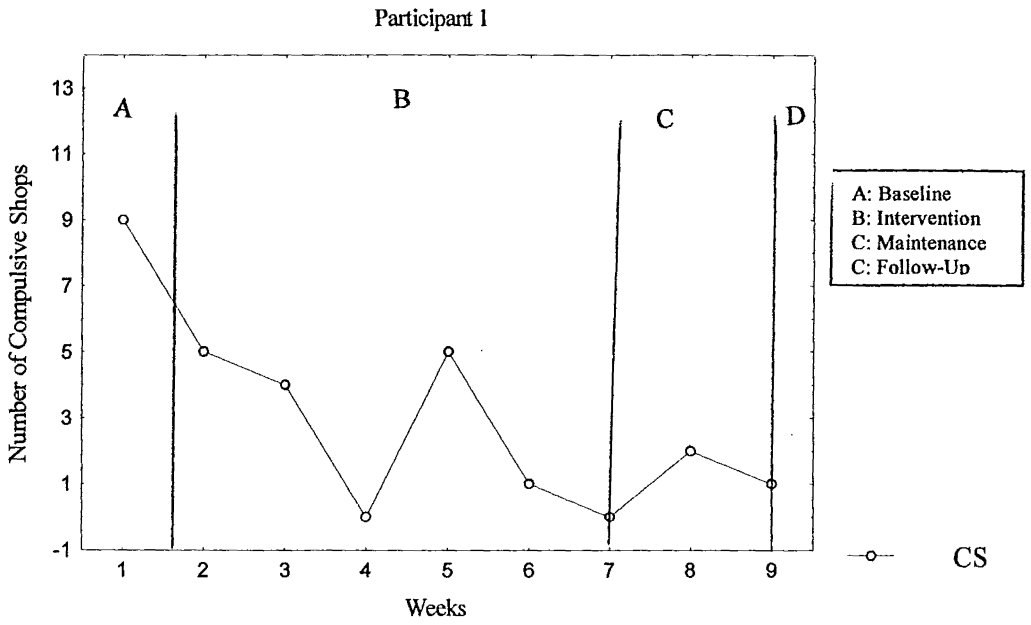

Fig 20. The compulsive shopping frequency per week for Participant 1.

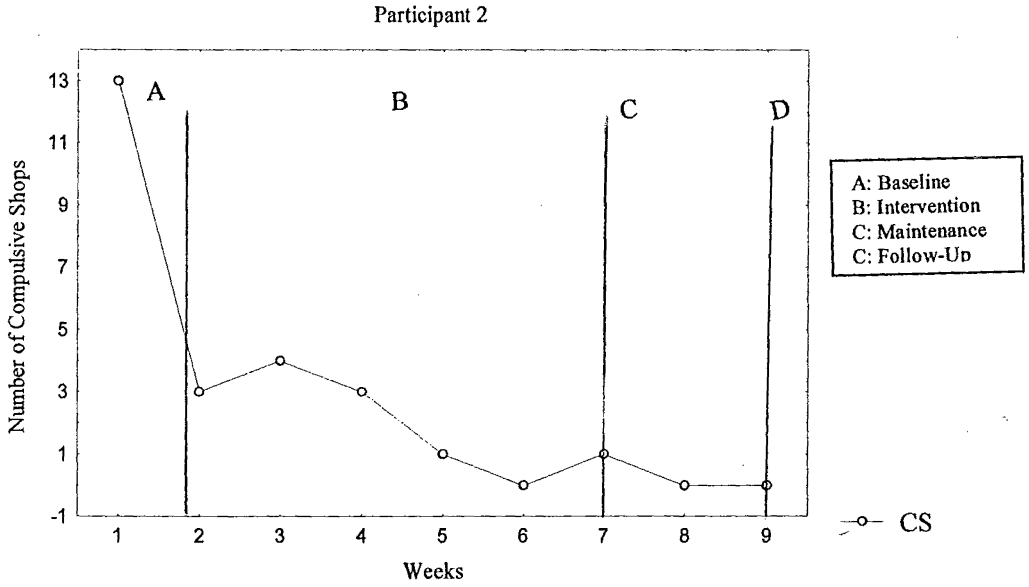

Fig 21. The compulsive shopping frequency per week for participant 2.

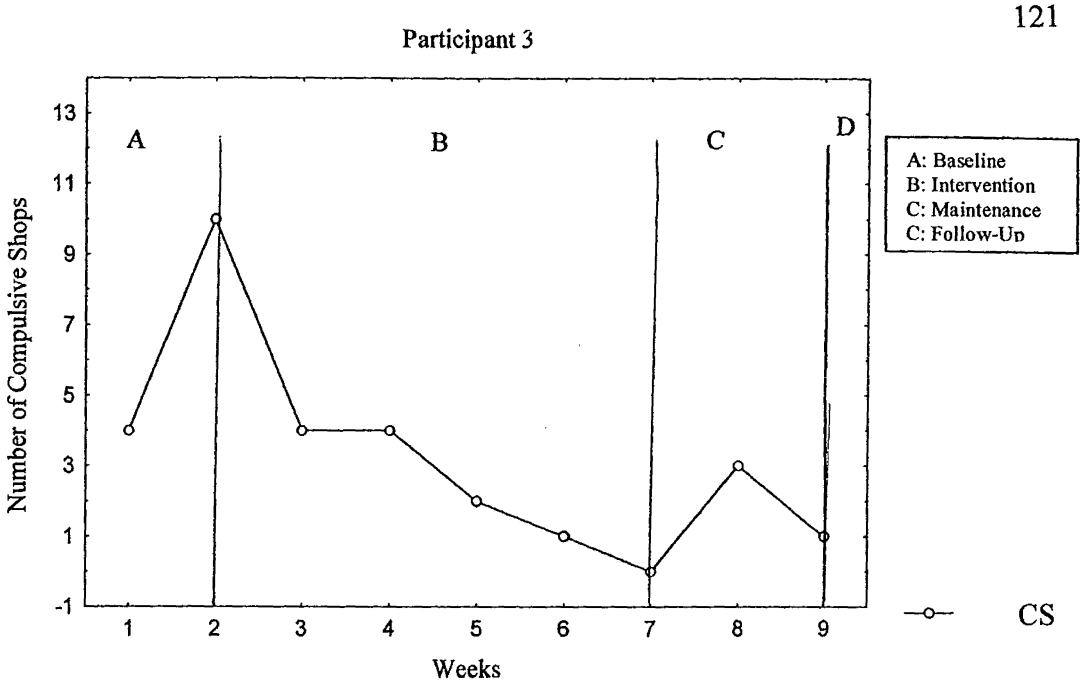

Fig 22. The compulsive shopping frequency per week for participant 3.

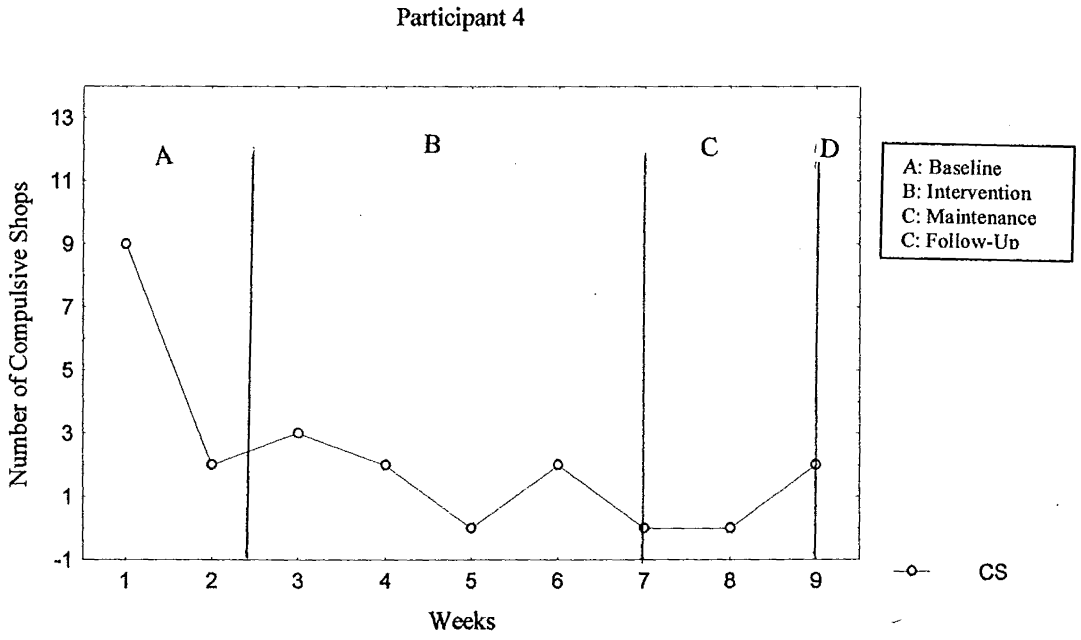

Fig 23. The compulsive shopping frequency per week for participant 4.

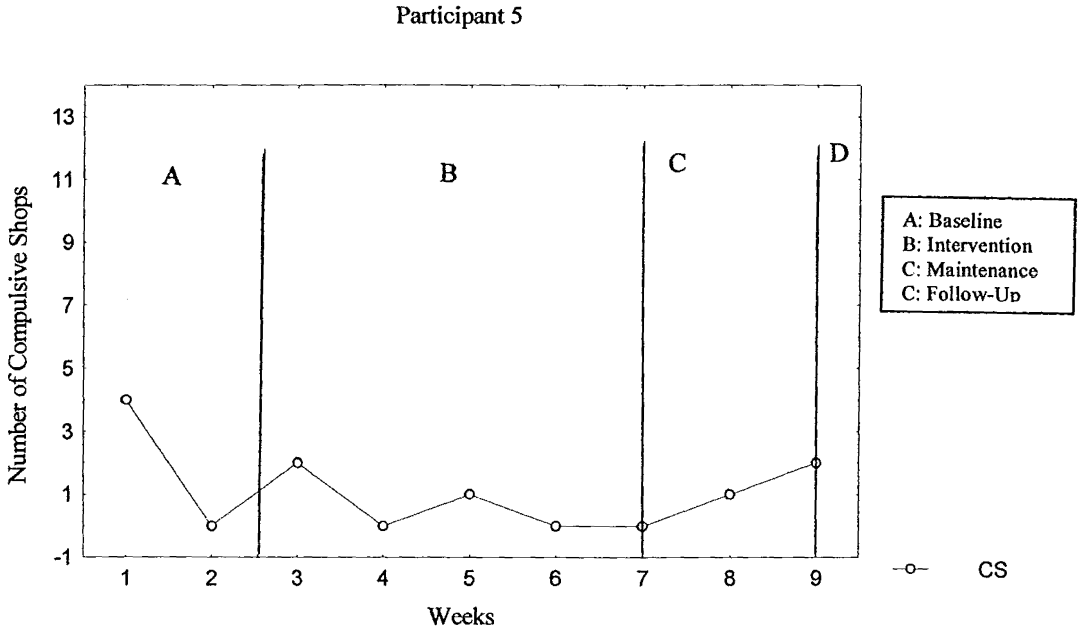

Fig 24. The compulsive shopping frequency per week for participant 5.

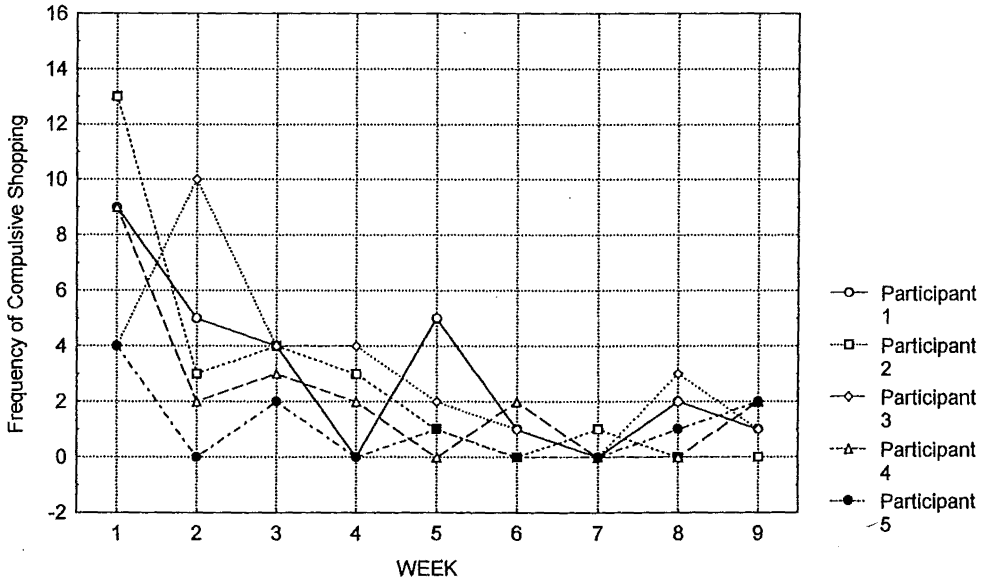

Fig 25. The compulsive shopping frequency per week for each of the five participants.

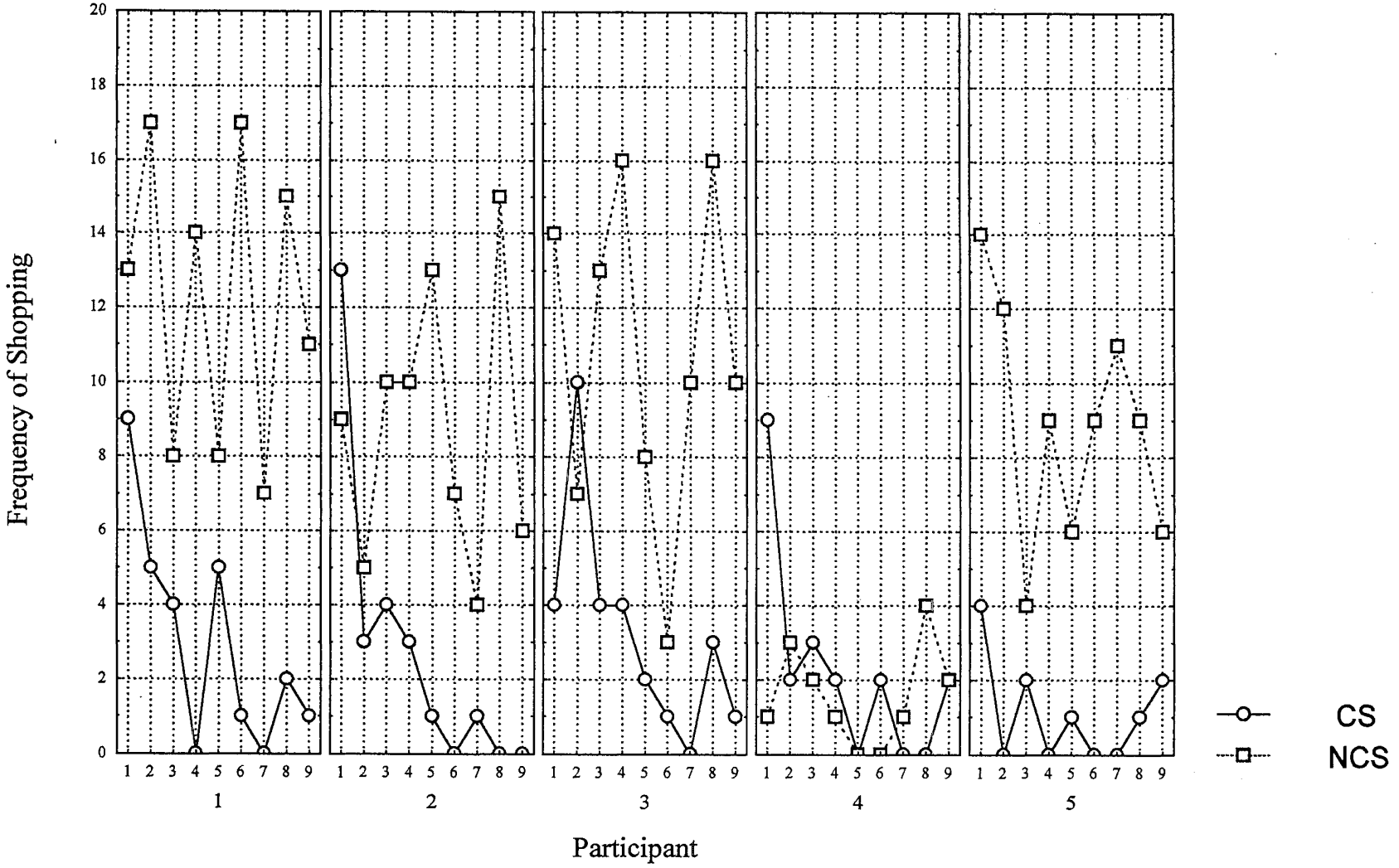

Fig 26. Individual line graphs for each of the five participants, plotting the compulsive shopping (CS) and non-compulsive shopping (NCS) frequency per week.

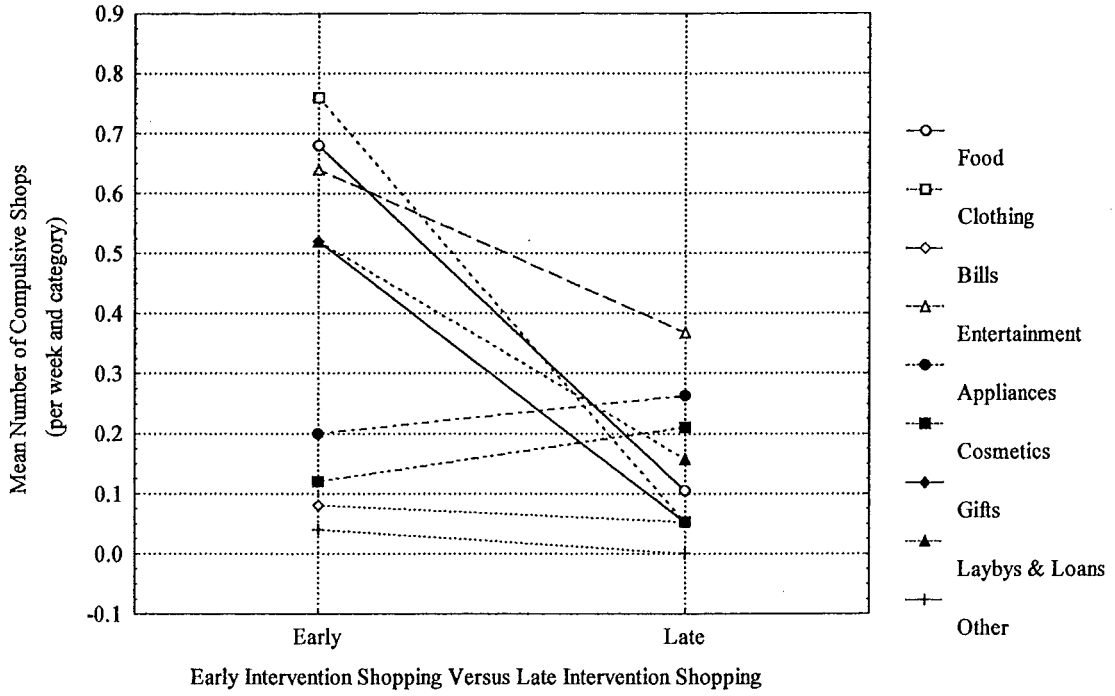

Fig 27. The mean number of purchases made within each purchase category (food, clothing, bills, entertainment, appliances, cosmetics, gifts, lay-bys & loans, and other) across the five participants, early intervention shopping (first 5 weeks) verses late intervention shopping (last 4 weeks of intervention and maintenance period).

4.2.3. Interpretation of the Compulsive Shopping Frequency Graphs

Figures 20 through to 25 display the compulsive shopping frequency per week for each individual participant across the duration of the psycho-educational programme, including baseline and follow-up. The one-month maintenance period that ended at follow-up is displayed in the graph from the end of week 7 to week 9.

Participant 1

There is a steady decline in the compulsive shopping frequency of Participant 1, from 9 compulsive shops during the first week of baseline down to 0 shops in week 4 (see figure 20). The frequency of compulsive shops increased to 5 in week 5 and decreased to 1 in week 6 and decreased further to 0 in week 7. During the maintenance period the shopping frequency increased from 0 to 2 in week 8 and decreased to 1 in week 9.

Participant 2

The compulsive shopping frequency of Participant 2 declined from 13 compulsive shops in the first week of baseline to 3 in the second week of baseline (see figure 21). The frequency increased to 4 in week 3 and then decreased by one compulsive shop per week until week 6 when the frequency reached 0. In week 7 the frequency increased to 1, but returned to 0 during the maintenance and follow-up period.

Participant 3

The frequency of compulsive shopping increased in the second week of the baseline period from 4 to 10 (see figure 22). At the commencement of the intervention programme

in week 3 the frequency of compulsive shopping decreased to 4 and continued to decrease and reached 0 in week 7. The frequency of shopping increased to 3 in week 8 although this decreased to 1 in week 9.

Participant 4

The frequency of compulsive shopping for Participant 4 decreased from 9 to 2 in the second week of baseline (see figure 23). The frequency increased to 3 in week 3 and then decreased by 1 compulsive shop per week and reached 0 in week 5. The frequency increased to 2 in week 6, then returned to 0 in week 7 and 8. During week 9 (maintenance period) the frequency increased to 2.

Participant 5

The frequency of compulsive shopping for Participant 5 decreased in the second week of baseline from 4 to 0 shops per week (see figure 24). The frequency increased in week 3 to 2 shops per week and then decreased to 0 in week 4. The shopping frequency remained below 2 shops per week until week 9 when there was an increase to 3.

Graph of Compulsive Shopping Frequencies of all Participants

The frequency of compulsive shopping decreased from the baseline period through to the maintenance of the psycho-educational programme in all five participants (see figure 25). Although there were fluctuations in the shopping frequency during the intervention for each participant the overall pattern evident in figure 25 is one of decrease.

Frequency of Compulsive Shopping and Non-Compulsive Shopping

Figure 26 shows the individual frequency of compulsive shopping and non-compulsive shopping for each of the participants across the duration of the intervention programme.

The frequency of compulsive shopping is lower than non-compulsive shopping frequency for Participants 1, 2, 3 and 5 (see figure 26). The frequency of non-compulsive shopping for Participant 4 was much the same as the frequency for compulsive shopping, due to the spouse of Participant 4 doing the majority of bill payments and grocery shopping.

The frequency of non-compulsive shopping tends to fluctuate on a weekly basis for Participants 1, 2, 3 and 5. In that the frequency if high one week and low the next, likely to reflect fortnightly bill payments and grocery shopping. This pattern is not evident in Participant 4 due to the low non-compulsive shopping frequency. An interruption in this cyclic increase and decrease of non-compulsive shopping frequency was evident in week 6 of Participant 3's shopping, this was the result of illness experienced by Participant 3 during that week.

Compulsive Shopping Purchase Categories

Figure 27 displays the mean number of compulsive shopping per week per shopping category. The types of purchases made were divided into nine different categories namely; food, clothing, bills, entertainment, appliances, cosmetics, gifts, lay-bys and loans and other.

Early intervention shopping involved all the compulsive shopping done in the first five weeks of intervention, and late intervention shopping involved all the compulsive shopping that took place in the last four weeks of the intervention and the maintenance period. At early intervention the purchases with the highest mean frequencies in compulsive shopping were clothing, food, entertainment, lay-bys and loans and gifts 0.75, 0.69, 0.64, 0.52 and 0.52 respectively (see figure 27). At late intervention the mean number of purchases made in these categories had decreased to 0.05, 0.1, 0.38, 0.15 and 0.8 respectively. The means for the bills and 'other' category had decreased slightly at late intervention from 0.08 to 0.05 and 0.05 to 0.0 respectively. The means for the categories of appliances and cosmetics increased slightly at late intervention from 0.2 to 0.26 and 0.12 to 0.21 respectively.

4.2.4. Interpretation of the Graphs Displaying Amount of Money Spent

Figures 28 to 32 display the total amount spent on compulsive and non-compulsive shopping per week for each participant, across the duration of the psycho-educational intervention programme.

Participant 1

The amount spent per week on non-compulsive shopping by Participant 1 fluctuated on a weekly basis and is likely to reflect the fortnightly payment of bills and grocery shopping (see figure 28). However it does not explain why the overall amount spent on non-compulsive shopping increased in the later half of the intervention programme from $893 in week 1 to $1640 in week 8.

The money spent by Participant 1 on compulsive shopping was around $136 per week for the first 3 weeks of the intervention programme. The amount spent tended to fluctuate through the duration of the intervention programme. The amount decreased to $0.00 in week 4, increased to $155 in week 5, decreased to $0.00 in week 6 and 7, increased to $160 in week 8 and decreased to $20 in week 9 (see figure 28).

Participant 2

The amount spent on non-compulsive shopping by Participant 2 fluctuated from $100 per week to $260 every four weeks (see figure 29). The graph does not show any overall increase or decrease in the money spent on non-compulsive shopping, as the fluctuations appear to be consistent and likely to reflect regular bill payments.

In comparison the money spent on non-compulsive shopping clearly decreased from $226 to $30 in the second week of baseline. There was an increase in the amount spent in weeks 3 and 4 to $62.00 and $95.00 respectively, although the amount spent decreased in week 5 to $9.40 and remained under $10.00 through to the end of week 7. The amount spent during weeks 6, 8 and 9 was $0.00.

Participant 3

The amount of money spent weekly both on non-compulsive shopping for Participant 3 decreased from $384 to $60 in the second week of baseline (see figure 30). The amount

spent by Participant 3 from week 3 through to week 9 fluctuated between $185 and $38 which is less than what was recorded during the baseline period of $384.

The amount spent by Participant 3 on non-compulsive shopping increased in the second week of baseline from $33 to $122, and then decreased in week 3 to $43. The amount spent per week from week 3 to week 7 remained under $43.00. In week 8 the amount spent increased to $116 and then decreased to $11 in week 9.

Participant 4

The amount of money spent by Participant 4 on non-compulsive shopping increased in the second week of baseline from $22 to $360 (see figure 31). The amount spent from week 3 to week 9 fluctuated weekly between $145 and $0.00.

The amount of money spent compulsive shopping by Participant 4 decreased from $190.00 in week 1 to $25 in week 2. The amount spent on compulsive shopping remained under $25 from week 2 until week 5, at week 6 the amount spent increased to $110. During week 7 and 8 the amount decreased to $0.00 and then increased to $100 at week 9.

Participant 5

The amount spent per week on compulsive and non-compulsive shopping by Participant 5 both decreased across the duration of the intervention (see figure 32).

The amount of money spent on non-compulsive shopping decreased from week 1 to week 3 from $610 to $30. The amount spent by Participant 5 fluctuated between $30 and $214 for the duration of the intervention.

The amount spent on non-compulsive shopping by Participant 5 decreased from $336 to $0.00 in the second week of baseline. In week 3 the amount increased to $125, in week 4 there was a decrease to $0.00. The amount spent on compulsive shopping remained under $30 during week 4, 5, 6 and 7. In week 8 there was an increase in money spent to $145 and in week 9 a decrease to $41.

4.2.4 Amount of Money Spent

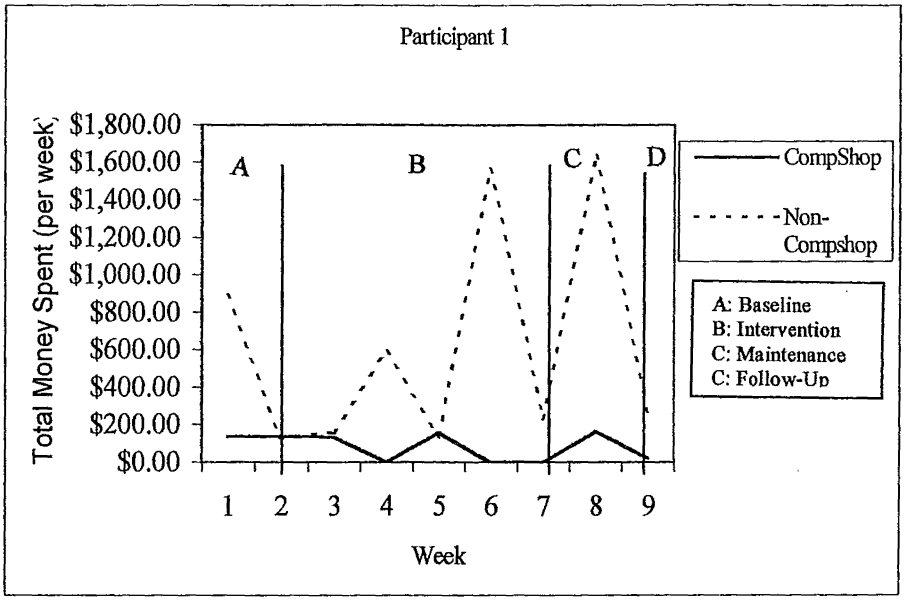

Figure 28. The total amount of money spent per week on compulsive and non-compulsive shopping for Participant 1, over the duration of the psycho-educational intervention programme.

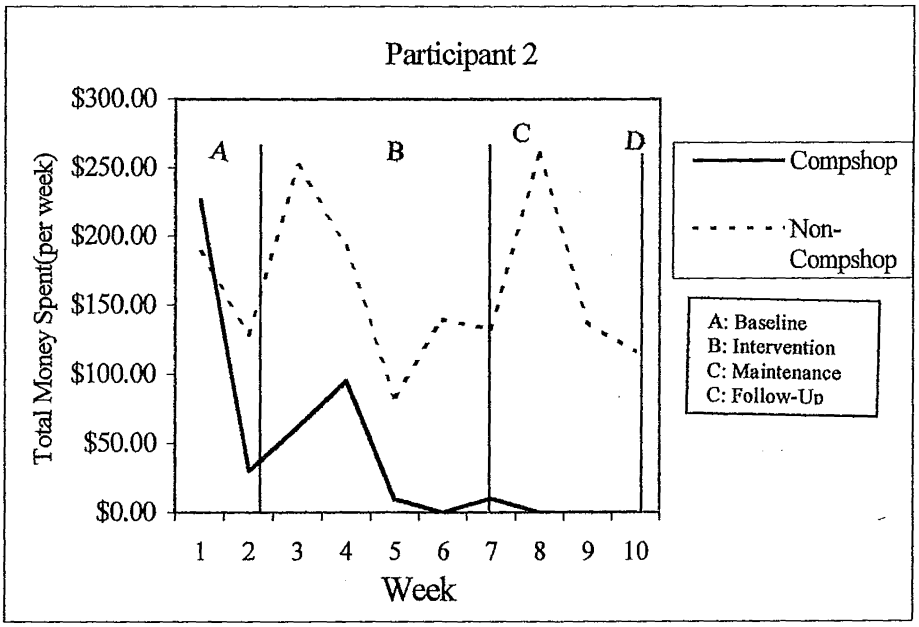

Figure 29. The total amount of money spent on compulsive and non-compulsive shopping per week for Participant 2, over the duration of the psycho-educational intervention programme.

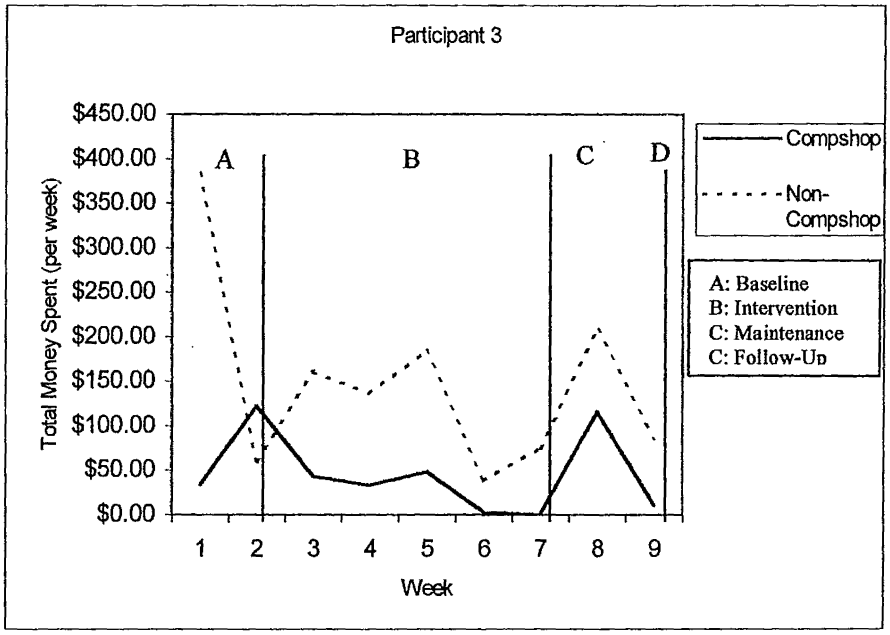

Figure 30. The total amount of money spent on compulsive and non-compulsive shopping per week for Participant 3, across the duration of the psycho-educational intervention programme.

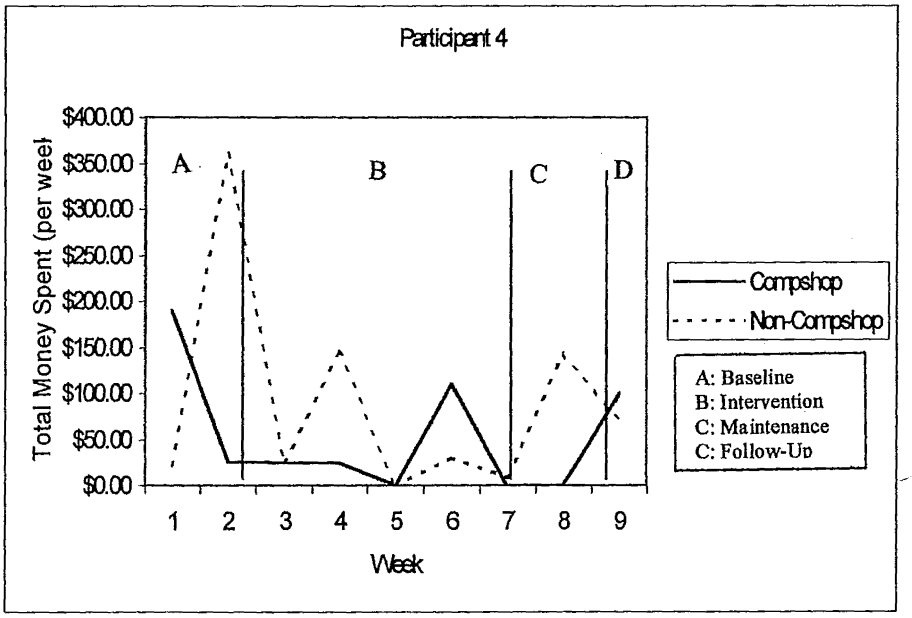

Figure 31. The total amount of money spent on compulsive and non-compulsive shopping per week for Participant 4, across the duration of the psycho-educational intervention programme.

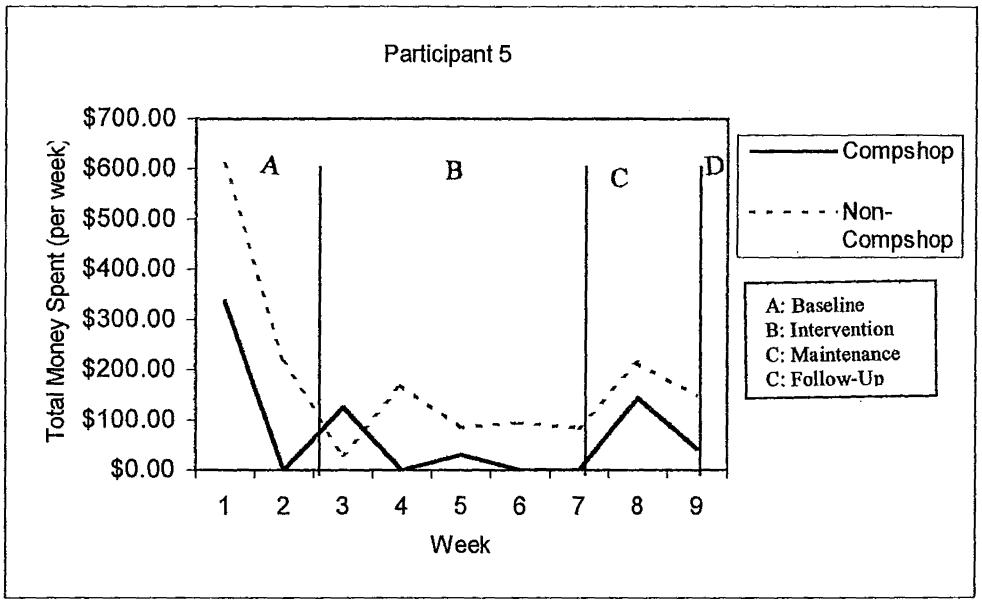

Figure 32. The total amount of money spent on compulsive and non compulsive shopping per week for Participant 5, across the duration of the psycho-educational intervention programme.

Chapter Five

Discussion

&

Conclusion

5.1 Discussion

All five participants were classified as compulsive shoppers using the Compulsive Buying Scale (Faber & O'Guinn, 1992) at the commencement of the programme, but only Participant 1 was classified as a compulsive shopper at the completion of the intervention period. Therefore the intervention was largely successful in changing the shopping behaviour of the participants. All five participants reported that their buying behaviour caused personal distress including interference with vocational work, marital and family disruption and financial problems before commencing the programme, however at the conclusion of the intervention period, significant improvement in these areas were reported in the psychological tests and questionnaires.

The results of the psychological tests showed substantial improvements in negative mood states, general health and self-efficacy. The COPE results revealed that the participants generally adhered to avoidance and emotion focussed coping strategies at pre-intervention, and at post-intervention the use of approach style strategies had increased while avoidance style strategies decreased.

The intervention was successful in reducing the frequency of compulsive shopping performed at post-intervention for all the participants. In general the graphs of shopping frequency reveal a steady decline in the frequency of compulsive shopping from the baseline period through to the maintenance programme.

Interestingly, a decline in shopping frequency was often evident during the second week of the baseline prior to the commencement of the intervention. This in part can be explained as the result of the baseline measures and procedures used namely; self-awareness tasks and the semi-structured interview. The daily diary task used to collect baseline data trained the participants in self-awareness. Through the completion of the diaries the participants became aware of the antecedents and consequences of their compulsive shopping. They also learnt how to recognise and label the emotions they experienced prior, during and after a compulsive shop, which encapsulates one of the major components of emotional intelligence (Goleman, 1996; Salovey & Mayer, 1989). Talking with the researcher in the semi-structured interview may have further developed the participants' self-awareness and understanding of their behaviour. It unmasked some of the mystery behind the compulsion, and alleviated some of its puzzling qualities as the participants had begun to understand the antecedents and reinforcements the behaviour provided. To reduce this effect, future research may instead only collect information regarding the amount spent and the purchases made during the baseline period. There is, however, a constraint on this, as without a level of self-awareness and understanding of the antecedents of the behaviour the participants may not be able to distinguish between a normal and a compulsive shop as readily, therefore the baseline data may not be as accurate. Furthermore knowing that compulsive shopping causes personal distress, postponing intervention for the sake of a clear baseline may not be ethical.

There was a decline found not only in the shopping frequency but also in the expenditure of money on compulsive shopping. Therefore the decline recorded in shopping frequency

was not the result of purchasing less but spending the same amount of money on more expensive items. Likewise there was no evidence in the data that would suggest the decrease in compulsive shopping frequency and money expenditure was due to the behaviour being mislabelled or relabelled as non-compulsive shopping. Although non-compulsive shopping tended to fluctuate on a fortnightly basis overall spending did not increase. Further support for the conclusion that the intervention specifically targeted compulsive shopping behaviour is gained through the analysis of the purchase categories. A decrease in the mean number of purchases made within categories generally associated with compulsive shopping (e.g., clothing, entertainment, food, lay-bys and gifts) was observed at post-intervention.

5.1.1 Demographic and Phenomenological Data

The demographic and phenomenological data collected is in agreement with prior research (Christenson et al., 1994; Elliot, 1994, McElroy et al. 1994; O'Guinn & Faber, 1989). The five participants in this compulsive shopping intervention study were European women with a mean age of 37 years (range 26 to 42 years) whose compulsive shopping behaviour developed during their late teens, although was only realised as a problem in recent years. The marriage status of the participants varied, two of the participants were married, one was separated, one was divorced and another was single. Four of the five participants had at least two dependent children with ages ranging from 7 months to 23 years. The average annual income was $30,000, only one participant possessed credit cards, and two possessed and used store cards. Four of the five

participants had sought professional help in the past for the related problems of depression and anxiety.

The participants would shop compulsively on average two to three times a week, the duration of shopping ranged from 10 minutes to 8 hours and was largely dependent on the amount of time available. It was often reported that the participants would lose track of time when shopping and would be late to meet friends or to pick up children. This provides support to the theory of cognitive narrowing involved in compulsive shopping presented in the *escape from aversive self-awareness* model (Heatherton and Baumeister, 1991), the *replacement theory* (Strongman, 1984), the *self-regulation failure* theory (Baumeister & Heatherton, 1996) and the theory of *distorted autonomy* (Scherhorn, 1990).

The shopping behaviour and the purchases bought were largely unplanned, in general the participants would decide on the day that they would go shopping. Four of the participants generally purchased items on sale or items considered as bargains. Buying out of fear that they would 'miss out' if they did not make the purchase that day was often reported. Purchasing out of fear of 'missing out' if they waited is an example of *mis-regulation* in that the buying provides short-term relief of the anxiety caused by the possibility of missing out at the expense of the long-term goal of saving money or paying off debt. It is also an example of avoidance behaviour performed on the basis of the cognitive distortion called the *fortune teller error* (Burns, 1992). That is, they believe that

purchasing the item will prevent or avoids the negative occurrence of missing out on the purchase that may happen if they were to wait.

The majority of the purchases were appearance related and included such items as clothing, shoes, accessories (e.g., jewellery and sunglasses) as well as items for the home, furniture, kitchen appliances, food and gifts for other people. The shopping experience and the purchases made seem to enhance the persons' self-image and self-esteem and alleviate feelings of inadequacy.

Whether the purchases were kept, hidden, returned or given away was dependent on the circumstances of the participant. The likelihood of participants hiding or returning their purchases was increased when the money spent was perceived to be their spouses. Some compulsive shoppers attached more sentimental value to their purchases than others, and the level of sentimental value was the determining factor as to whether the purchases were kept when they were no longer needed or given away.

The emotions reported by the participants in both the semi-structured interview and daily diary entries supported earlier findings. Prior to shopping the participants generally experienced negative emotions such as anxiety, depression, tension and frustration. In the case of one participant, however, the emotions experienced prior to shopping were positive such as feeling good about herself and happy (Christenson et al. 1994).
The act of shopping replaced the negative emotions and tension experienced prior to shopping with positive emotions such as feeling happy, excited and pleased with one-self.

The elevation in mood is an expected result of both positive and negative reinforcement. Firstly the act of shopping provided the compulsive shoppers with both cognitive and behavioural escape from their lives, as argued by *the escape from aversive self-awareness* model (Heatherton & Baumeister, 1991) and by *replacement theory* (Strongman, 1984). Activities at shopping malls provided negative reinforcement by temporarily alleviating cognitive awareness of life events or situations that were causing stress, anxiety and/or depression. The act of shopping was also positively reinforcing by providing opportunities to socially interact with salespersons, and to purchase items perceived to enhance self-image, either by the purchasing of items that enhance appearance and/or social status, or by buying gifts for others that would in turn make the shopper feel generous and loving. As mentioned earlier, a behaviour that provides both negative and positive reinforcement is likely to be repeated and develop into very strong (and in the case of compulsive shopping) emotional habit. In some cases anxiety would accompany the buying process due to the apprehension as to whether the purchase being made could be afforded.

The positive effects of shopping on the participants' mood were short lived and often replaced with feelings of regret, disappointment, guilt and anxiety. The negative emotions seemed dependent on whether the person could afford the items and also whether they had someone they were accountable to such as a spouse, family member or friend. This in part explains why there is a time lag between the developmental onset (late teens) of compulsive shopping and recognition of the problem (on average at 36 years of age). It is not until the behaviour results in financial and personal distress, involving accountability

that the behaviour is recognised as problematic even though the symptomatic behaviour has been evident for years.

The results revealed that the majority of participants had family members who also shopped compulsively. Either their parents compulsively shopped or their own sons and/or daughters had begun to behave in a similar way. These findings support a social learning theory viewpoint. Compulsive shopping behaviour and the contingent reinforcement it provides is likely to be observed by children within the family, who, in turn, model and pattern this behaviour once they acquire the financial resources enabling them to do so (Bandura & Walters, 1963; Faber, 1992).

This study has gone beyond the scope of previous research in a number of ways. Firstly, although previous researcher had suggested the possible merits of intervention programmes (Elliot, 1994; Scherhorn, 1990) this was the first study to design, apply and evaluate an intervention programme for compulsive shopping. Furthermore, previous research had not formally used appropriate psychological tests that evaluated the styles of coping strategies utilised by people who shop compulsively, although from the literature it was suggested that avoidance and emotion-focussed coping strategies would be prominent (Baumeister & Heatherton, 1996; Zeidner & Saklofske, 1996).

Research investigating psychological interventions for eating disorders have largely involved CBT methods, placing emphasis on evaluating the environmental antecedents and consequences of their eating behaviour, and designing therapy to address these

components (Thackaway et al., 1993; Wadden & Letizia, 1992; Wolf, 1990). The current study used a functional analysis of the environmental and emotional antecedents and consequences of the shopping behaviour and although common in other areas of CBT it had not previously been reported in the literature on compulsive shopping. The value of such an analysis had been stressed by Elliot (1994), as it would facilitate in the design and effective application of intervention programmes for compulsive shopping. It could be argued that the results from the functional analysis (daily diaries) are methodologically more sound than those based on retrospective accounts through semi-structured interviews. It is unlikely that people who shop compulsively and describe their behaviour as 'puzzling' (Scherhorn, 1990) would be able to accurately pinpoint the environmental and emotional antecedents of their behaviour, but the daily diaries used in the intervention trained self-awareness and self-monitoring enabling more accurate accounts to be reported.

The results of the research discussed above have shown that the psycho-educational intervention programme was effective in reducing the frequency and money expenditure of compulsive shopping in the five participants that took part in the programme. The findings also give support to the three hypotheses presented earlier. Firstly that people that compulsive shop will score higher tests on negative affect and lower on tests of self-efficacy. Secondly their compulsive shopping acts as an avoidance coping strategy used to regulate negative mood in that compulsive shoppers will generally use more avoidance and emotion focussed strategies rather than approach-style strategies to cope with life stressors. Thirdly the research findings support the hypothesis that when approach style

coping strategies, cognitive restructuring and mood regulation techniques are taught and regularly applied, positive affect and self-efficacy will increase and the frequency of compulsive shopping and money expenditure will decrease.

5.1.2 Research Limitations

The results of this research, although promising, are tentative, as there were a number of aspects that could be improved to enhance and strengthen future research findings. Firstly, a control group of compulsive shoppers could have been included that would complete the daily diaries and meet with the researcher on a weekly basis for the duration of the intervention. This would help ascertain whether improvement in shopping behaviour and psychological tests were due to the skills taught during the intervention, or rather the weekly contact and communication with the researcher that brought about the effect. However without some incentive such as payment it might be difficult to maintain participants' commitment and compliance. Also, having a control group of compulsive shoppers is perhaps not ethical due to the fact that the behaviour is known to cause emotional, relational and financial distress.

To help distinguish the effects of the baseline measures (self-awareness and self-monitoring) on compulsive shopping prior to the intervention the duration of the baselines could have been increased and more staggered between participants. Another alternative would be to have some participants' record only their spending and purchases made, without recording the emotions, antecedents and consequences of the behaviour

until the commencement of the intervention. As this would limit the amount of self-awareness and self-monitoring learnt prior to the intervention programme.

The filling out of the daily diaries decreased slightly during the maintenance period and this could have had an effect on the results. Future research could minimise this potential bias by meeting briefly with the participants each week during the maintenance period to check their records, or by providing some kind of incentive for the continuation of the diaries through to the follow-up period.

The psychological measurements could have been improved by administering the tests three times, at the commencement and completion of the intervention and again at the end of the follow-up period. It was the intention of the researcher to take the extra measurement at the completion of training, however regardless of clear instructions none of the participants completed and returned these tests to the researcher.

The effectiveness of the intervention programme could be improved by addressing the external problems of the compulsive shopper, namely marital and family discord. For example Participant 1 improved greatly from the pre to post-intervention although she still meet the criteria for a compulsive shopper at the completion of the programme. This was believed to be due to antecedents of her shopping behaviour primarily being an unhappy marriage and a verbally abusive family environment. Although the techniques taught during the intervention were helpful, there was a ceiling effect to their effectiveness due unchanging external influences. It is unrealistic to expect that the

teaching of coping and assertiveness skills to one spouse can in itself heal a marriage and family unit without direct co-operation and support from the other family members. Therefore in cases where an individuals' compulsive shopping is a reflection of difficulties within the family unit it is likely that an intervention that includes the family would be more beneficial than individualised therapy (Mikesell, Lusterman & McDaniel, 1995). Given that the research findings show that marital discord and dissatisfaction influence compulsive shopping behaviour (Faber, 1992) it would be wise to administer a scale evaluating the satisfaction of these relationships and perhaps tailor the intervention to suit such problems (e.g., include sessions on couple counselling).

The generalisability of the results could be improved in future research by including men in the intervention sample, as all the participants in this study were women. Men did respond to the advertisement but did not choose to take part. The exact reasons as to why were not ascertained. It could have been the result of having a female researcher conduct the study, perhaps strengthening stereotyped ideas that it is a 'women's problem'. The times of the intervention sessions were flexible so should not have influenced the decision to participate. Perhaps an advertisement that requested only male participants for a compulsive shopping intervention programme, with a male researcher would increase male responses and compliance.

Another aspect that could improve the findings of the study would be including more independent measures of the participants shopping behaviour, as this research was based primarily on self-report data that adds to the potential bias of the findings (Chambles &

Hollon, 1998). To gain independent measures of the amount of money spent on purchases bank statements could be requested, although the person is likely to view this as an invasion of privacy and quite rightly so.

The maintenance of the improved shopping behaviour and/or better emotional regulation could be strengthened by increasing the duration of the intervention, allowing more time to consolidate the information gained and stabilise their new behavioural patterns learned. Other methods that could enhance maintenance could include booster sessions (meeting with the participants at sometime after the completion of the intervention), organising a buddy system (between the participants to provide mutual ongoing support), or setting up an 0800 hotline that compulsive shoppers could phone for help.

The findings of this research although positive are still tentative and require replication by other independent researchers, taking into account, modifying and overcoming some of the limitations of this present research. Further investigation is also needed to evaluate the relative effectiveness of each of the individual techniques taught in this psycho-educational intervention programme through systematic replication (Chambles & Hollon, 1998), especially in light of the decline in shopping behaviour observed in the second week of baseline after the self-awareness and self-monitoring were taught.

5.2 Conclusion

The research findings of this study provide support for the effectiveness of a psycho-educational intervention programme designed for compulsive shopping. The programme addressed the central problematic antecedents of the shopping behaviour which were negative affect experienced as the result of an inability to employ active coping strategies to manage life stressors, leading to the application of avoidance and emotion based coping strategies in order to regulate negative mood, primarily depression, anxiety and stress.

The current research placed emphasis on enhancing self-efficacy by teaching techniques such as self-awareness, adaptive approach style copping skills and alternative emotion regulation. These techniques used in the intervention were shown to have a positive effect on the participants' self-efficacy, emotional states and in the application of approach-style coping strategies.

The intervention was successful in decreasing compulsive shopping frequency and money expenditure in all participants. Past research on therapeutic intervention for compulsive shopping has been predominantly pharmacological and its effectiveness has been shown to limited and cause problematic side effects (Black et al., 1997; Kim, 1998; McElroy et al., 1994). Based on the current findings of this research it is suggested that

the psycho-educational intervention programme could provide an alternative therapeutic intervention to the pharmacological treatments commonly employed.

The effectiveness of the psycho-educational intervention programme in treating compulsive shopping behaviour has been tentatively demonstrated in this research. This thesis emphasised the importance of identifying and addressing the antecedents of compulsive shopping (negative affect, life stressors, and coping strategies) in providing therapeutic intervention rather than centring therapeutic focus on the symptoms of the behaviour, that is, shopping. Based on the results it is apparent that a shift in the orientation of therapeutic intervention from pharmacological to psycho-educational is clearly warranted and necessary in order to validate these findings and to aid in the development of more effective therapeutic interventions for compulsive shopping.

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Appendix 1
Psycho-Intervention Mannual

Psycho-educational Intervention Program Manual:
Designed to Alleviate the Symptoms of Compulsive Shopping by Training Self-awareness, Emotional Discrimination and Adaptive Coping Strategies.

Prior to Session 1

Prior to session one all respondents to the newspaper advertisement (Appendix 3) were sent the following; 1) an information sheet that outlined what participation in the intervention program would involve. 2) A list of general characteristics of compulsive shoppers, 3) a map of the university with the room where the sessions would take place circled along with convenient parking areas.

University of Canterbury
Department of Psychology

Information Sheet

Outlining Participation in the Research Project Investigating the Efficacy of an Intervention Program Designed to Alleviate the Symptoms of Compulsive Shopping.

Dear...
Thank-you for your response to the newspaper advertisement regarding the compulsive shopping intervention program. I would like to formally invite you to participate in this research project investigating the efficacy of a psycho-educational intervention program designed to alleviate the symptoms of compulsive shopping. Information regarding the intervention program and what your participation in the program would involve is outlined below.

The Aims of the Project

The aim of this project is to gain more information on the subjective experience of the compulsive shopper and pilot test the effectiveness of a psycho-educational intervention program. The aim of the program is to alleviate the symptoms of compulsive shopping, empower its participants through increasing self-awareness and emotional discrimination through education and application of adaptive coping strategies.

Participation

Your participation in this project will involve meeting weekly with the researcher for 9 one-hour sessions. In the initial stages 3 psychological tests and 2 questionnaires will need to be completed as well as a semi-structured interview conducted by the researcher (the interview will be tape-recorded but only the researcher and her supervisor will have access to the tape). The sessions will be conducted individually

in an office at The University of Canterbury. A subsidy of $10 will be given to help cover travel costs to and from the university.

Daily Tasks

During the program you will be provided with diaries and asked to keep daily entries recording your shopping activities (such as how much time and money you spent and how you felt before, during and after the shopping experience). It is estimated that the diaries will take about 10 minutes a day to complete.
Participation will also involve using the techniques and the coping strategies taught during the sessions in your everyday life.
At the completion of the intervention sessions there is a one-month maintenance program where you will devise with the researcher a maintenance plan to prevent relapse. During this one-month maintenance program you are asked to continue writing in the daily diaries as this self-monitoring will aid in maintaining your progress as well as provide the researcher with valuable data.

Follow Up

To investigate whether your progress is maintained you will be asked to meet again with the researcher one month after the completion of the program. The follow up consists of one more session with the researcher. You will be asked to fill out again the tests and questionnaires that you completed at the beginning of the program, to help assess your progress. You will also be given an evaluation sheet asking for your opinion on the effectiveness of the intervention and ways in which it could be improved.

You are asked to work in collaboration with the researcher giving feedback on how the program is working for you, and based on your feedback the program can be tailored to suit your personal needs.

Significant Others

You will also be asked to provide a name and contact number of a significant other that could complete a questionnaire regarding the impact they perceive compulsive shopping has on you. To ensure independent and unbiased information is given by the significant other this questionnaire will only be viewed by the researcher and supervisor of this project.

Results and Confidentiality

The results of the project may be published, but you may be assured of complete confidentiality of data gathered during the investigation, as the identity of participants will not be made public. To ensure anonymity and confidentiality all information gathered will be kept either in a locked filing cabinet or on a computer file locked with a password. Only the researcher, Megan Garner and her supervisor Neville Blampied will have access to the files.
At the completion of the project you will be given back all the raw data that was collected including the questionnaires and the tape recording of the semi-structured interview. Any data you do not wish to keep will be destroyed along with the questionnaire completed by your significant other.
If you wish to withdraw from the project at any time you are able to do so, as well as withdraw any information that you may have provided.

Consent Form

During your first session, Megan will ensure that you understand the information written above and provided that you are comfortable with the conditions of this program she will ask you to sign a consent slip agreeing to participate.

Thank-you again for your interest in this program, and I look forward to meeting with you soon.

Yours Sincerely

Megan Garner

Contact Details

Megan Garner is carrying out this project as a requirement of a Masters of Science degree in Psychology under the supervision of Neville Blampied. The contact numbers are listed below, do not hesitate to contact either Megan or Neville to discuss any concerns you may have about participation in the project.
Neville Blampied: (03) 366 7001
Megan Garner: (03) 364 2987 ext. 7708

The University of Canterbury Human Ethics Committee has reviewed the project.

Some General Characteristics of Compulsive Shoppers

1. Frequently experience irresistible urges to buy
2. Frequently buy items that they do not need or use
3. Frequently experience irresistible urges to buy
4. Frequently shop for longer periods than expected
5. Frequently go shopping to relieve feelings of anxiety of depression
6. Frequently buy more than can be afforded
7. Experience feelings of guilt regarding their purchases
8. May experience personal distress from their shopping behaviour
9. May find their shopping interferes with social or occupational functioning

Session 1: Baseline

Duration: 1 hour
Objectives & Guidelines

1. Introductions to be made and a good rapport built between the participant and the researcher.

2. Work through the information sheet that had been sent out prior to this session and answer any questions the participant may have regarding the research.

3. Confirm that the participant meets the criteria for being a compulsive shopper by filling out a quick Compulsive Buying Scale (Appendix 2).

4. Work through the handout for this session that outlines a) the current research and treatment of compulsive shopping b) the psycho-educational model and c) behaviour modification. Then answer any questions the participant may have.

5. Now that the participant is well informed regarding the details of the program they are invited to participate and sign a consent form.

6. Give out the psychological tests and questionnaires explaining how they are to be filled out (Appendix 2). These are to be completed at home, and sent back to the researcher before session 2 (envelopes with prepaid postage are provided).

7. Give out the Daily Dairies and the examples of how they are to be filled out as well as the sheet of emotions to help the participant name his/her emotions in their diaries. The researcher will stress and explain the importance of this task being performed regularly and in as much detail as possible.

8. Organise a time for session 2: The Semi-Structured Interview.

Home Work:

1. Fill out and return the psychological tests and questionnaires
2. Complete the daily diaries

Session 1: Handout

Current Research and Treatment

Psychological research on compulsive shopping has shown that this problem shares significant similarities with other problems related to anxiety and depression. Research has found that these problems have been effectively treated using Behaviour change techniques. However there has not been a program designed using these techniques to specifically treat compulsive shopping, instead the primary treatment for compulsive shopping reported in psychological literature has been drug based. The aim of this research program is to measure the effectiveness of a psycho-educational intervention program designed to teach you how to control urges to shop by managing those areas of your life which cause you anxiety and distress.

Psycho-educational Model

The psycho-educational intervention program used in this research program is designed to help understand and alleviate the symptoms of compulsive shopping. The psycho-educational model is largely based on **Behaviour Change** techniques that apply the Principles of Learning to help improve people's thoughts, feelings and actions. One of the main goals of the psycho-education approach is to clarify the means by which behaviour is changed so people can take a more active role in changing their own unwanted behaviour. During this program the various Principles of Learning will be outlined and how these principles relate to Compulsive Shopping.

Behaviour Change

Behaviour change involves the systematic application of behaviour principles to help people understand and stop undesirable behaviours and learn to replace them with desirable ones. Researchers have developed effective methods of behaviour change to help people increase their creativity and physical fitness, overcome irrational fears and panic attacks, learn social and acting skills, stop smoking or drug abuse, alleviate depression and much more.

The successfulness of the psycho-educational program is largely based on how effectively certain steps are followed. These steps are listed below.

1. Identify and Define the Target Behaviours

In this program the target behaviour is compulsive shopping. However each person's experience of compulsive shopping will be different according to the different amounts of time and money people spend and the different types of purchases made. For example for one person compulsive shopping may involve large amounts of money and very little time, while for someone else it may involve spending large amounts of time at the mall and relatively small amounts of money.
The reasons why each person shops may also be different, shopping may be a way of dealing with anxiety, depression or boredom.

2. Establish Goals

Based on the target behaviours you identified in your compulsive shopping, you and the researcher will discuss the goals that you wish to achieve during the intervention program. For example if it was the amount of time spent shopping that was causing the most concern, the number one goal of the program would be to help you reduce the time spent shopping and perhaps a secondary goal would be to reduce the amount of money spent. The psycho-educational program can be tailored to fit your individual goals and meet your individual needs.

3. Understanding Patterns in Behaviour

The qualitative analysis in this intervention is based on the daily diaries that you keep. The completion of the daily diary is perhaps the most important aspect of the psycho-educational program, as it will be used to establish what happens prior to, during and after a compulsive shop that will give understanding regarding what triggers and maintains your shopping behaviour. It will also establish how much time and money

is spent shopping and provides a clear baseline to measure the amount of progress you make during the program.

The more detailed your dairies are the more effective the program will be. As you yourself will be able to identify and gain a greater understanding of your behaviour patterns, putting you in a more powerful position to be able to change your behaviour as well as measure your progress.

4. Information Collection

The data collection used in this psycho-educational program involves psychological tests, questionnaires, the completion of daily diaries and a one on one interview with the researcher.

Consent Form

I have read and understood the description of the psycho-educational intervention program. On this basis I agree to participate as a subject in the project, and consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may withdraw from the project including withdrawal of any information I have provided.

Signed..... **Date**.....

Do you give consent to the researcher to contact a significant other whom you have nominated to answer a questionnaire regarding their perception of the impact compulsive shopping has on you?
Please circle: **YES or NO**

If Yes, Do you understand that you will not have access to the information the significant other provides?
Please circle: YES or NO

Please write below the name, address and contact number of the significant other that you wish the researcher to contact.
Name:
Relationship (e.g. friend, mother):
Address:

Phone number:

Signed ..... Date.....

Example of Daily Diary

Below is an example of how the daily-accounts diary is to be filled out. In this diary all the purchases made during the day are recorded. An asterisk (*) is put in date column of any purchase that was compulsive. Any purchases that were compulsive are then written up in the other daily diary explaining these purchases in more detail.

DATE	PUCHASE/S	TIME SPENT	MONEY SPENT	PLANNED PURCHASE	NEEDED PURCHASE	IF YOU COULD DO IT AGAIN WOULD YOU STILL BUY IT?
12 May	Petrol	10 mins	$20	Yes	yes	Yes
*	Shoes	10mins	$39.95	No	No	Yes
	Movie Tickets	5 mins	$8	No	No	Yes
	Lollies	20 mins	$2	Yes	Yes	Yes
14th May	Apples	10 mins	$1.40	Yes	Yes	Yes

Based on the previous table, describe the situation around the item/s marked with an * that were the result of a compulsive shop.
Date: 12 May **Purchase: Jumper**

What Happened before you went shopping?

Before shopping?	What did you do/ Where did you go?	Before Buying?	Immediately after buying	What happened after you went shopping?	Thoughts and Emotions now
Thoughts: I picked up a friend who needed me to take her to the doctors. I had other things to get done. But it was more important for me to be there for her. **Emotions:** **HAPPY** She needed me. Slightly concerned about the work I had to get done. **Level of Emotion:** Happy 3 **Desire to shop 0 %**	After the doctors she was upset because of what the doctor had said. It was a miserable day and I didn't want to leave her, so we decided to go and see a movie. We went to the mall first to pick up her prescription and while waiting for that we window shopped. Found this jumper that I had wanted for ages on sale with 50% off!!!!!	**Thoughts:** Even if it was half price I can't really afford it. I have to pay bills this week and I don't really need it. **Emotions:** **EXCITED** Excited that it is on sale and there is one in my size. **ANXIOUS:** because I don't really have the money. Still worried about my work. **Level of emotion:** Excited 4 Anxious 2 **Desire to Shop: 90%**	**Thoughts:** Not so worried about the money because it's done now. And I know that I will wear it. I still have work to do **Emotions:** **PLEASED,** I got a bargain and I have wanted it for ages. **Level of Emotion:** Pleased 3 **Desire to Shop: 0 %**	After I bought the jumper we went straight to the movies as we were already a little late for the session.	**Thoughts:** I am a little worried about my purchase because I have bills to pay. And it is a while before money comes in again. **Emotions:** **WORRIED** **GUILTY** , I don't really need the jumper, and I had promised myself I would stick to my budget. **Level of Emotion:** Worried 3 Guilty 4 **Desire to Shop:0 %**

Level of Emotion: Is rated on a scale from 1 through to 5.
1 - No emotion 2 - Slight Level 3 - Mild Level 4 - High levels 5 - Extremely High levels

Desire to shop rating: 0 %– not at all
100 %– overwhelming desire to shop

Level of Emotion: Rate your level of emotion on a scale from 1 through to 5.
1=No Emotion 2=Slight Level 3=Mild Level 4=High level 5=Extremely High

Desire to shop rating: 0 %– not at all
100 %– overwhelming desire to shop

Naming the Emotions

HAPPINESS	SADNESS	ANGER	LOVE & FRIENSHIP	FEAR	DISTRESS
Elated	Miserable	Fuming	Adoring	Dreadful	Anguished
Giddy	Crushed	Furious	Devoted	Panicky	Disgusted
Overjoyed	Worthless	Outraged	Passionate	Horrified	Speechless
Radiant	Humiliated	Incensed	Amorous	Terrified	Tormented
Ecstatic	Depressed	Burned-up	Tender	Petrified	Sickened
Jubilant	Helpless	Hateful	Ardent	Desperate	Afflicted
Tickled	Forlorn	Disgusted	Caring	Alarmed	Badgered
Glowing	Burdened	Irritated	Dedicated	Fearful	Bewildered
Excited	Slighted	Aggravated	Generous	Jittery	Confused
Joyous	Abused	Biting	Loving	Strained	Disturbed
Bubbly	Defeated	Hostile	Empathetic	Shaky	Impaired
Delighted	Dejected	Riled	Considerate	Threatened	Offended
Amused	Resigned	Peeved	Warm	Uneasy	Silly
Cheerful	Apathetic	Bugged	Amiable	Tense	Foolish
Pleased	Blue	Annoyed	Civil	Timid	Unsure
Relieved	Gloomy	Ruffled	Polite	Anxious	Touchy
Glad	Ignored	Nettled	Giving	Nervous	Lost
Serene	Glum	Cross	Kindly	Puzzled	Disturbed

Session 2: Baseline

Duration: 1 Hour
Objectives & Guidelines:

1. Discuss the results of the psychological tests with the participant.

2. Check the daily diaries are being filled out correctly. Photocopy the diary entries before returning the diaries to the participant (keeping a hard copy of the data).

3. Conduct and tape the semi-structured interview regarding the participants' compulsive shopping behaviour as well as some demographic data. An outline of the interview is given below. Note that the text in brackets was only used to help prompt answers when the participant did not seem to understand the question.

4. Answer any questions the participant may have.

Homework:

1. Complete daily diary

Researchers Copy
Semi-Structured Interview

Demographic Data:
Age: Sex:
Marriage Status:
Dependent Children:
Annual Personal Income:
[N.B: Because this interview is being taped to help ensure confidentiality with such details as personal income, the participant will be given a card with various income brackets corresponding to letter of the alphabet. The participants' response to the question regarding personal income will therefore be a single letter rather than a specific amount.]
Example of Card

A: $10,000-20,000	E: $80,000 – 100,000
B: $20,000-40,000	F: $100,000-150,000
C: $40,000-60,000	G: $150,000 +
D: $60,000-80,000	

Phenomenology

Age of Onset and Course of the Compulsive Buying
1. How old were you when you started compulsive shopping?
2. When did you realise that your shopping was a problem?

3. Could you describe for me the course of your shopping behaviour how it developed from normal to something distressing, mentioning any life circumstances that you think may have played a part in it's development?

Frequency and Purchases

1. On average how frequently do you go shopping? (e.g., 3 times a day...?)
2. Do you normally go shopping at a particular time of the day?
3. Do you normally plan what you are going to buy before you go shopping?
4. Have you gone shopping for bread and milk and come back with say a pair of shoes, or a dress? If yes, how often does that happen?
5. What kind of items do you buy most frequently? (e.g., stationary, shoes, art etc..)
6. Can you pinpoint certain situations that generally lead you to go shopping? (e.g., going out with friends? A bad day at work? An argument with a friend?).
7. How do you normally pay for your purchases? (e.g. cash, cheque, credit cards, eftpost ...)
8. Do you have a budget plan?
9. Do you know how much money you have in the bank at any particular time?

Emotions Experienced Prior, During and After Shopping

1.a Can you please describe for me how you feel just before you are about to buy something?

1.b Is that feeling different when you are buying something you don't need, or can't afford? (Do you experience any mounting tension or anxiety before buying?)

2.a Could you describe for me how you feel when you are in the process of buying something?

2.b Is that feeling different when the purchase is something you don't need or can't afford? (Do you experience a sense of relief or pleasure with buying?)

3.a How do you feel after you have been shopping?

3.b Is that feeling different when you have bought items that you didn't need or couldn't afford? (Do you experience a sense of guilt, regret or anxiety after buying?)

Specific Problems

1. Does your compulsive shopping cause you personal distress?
2. What is it about the compulsive shopping that causes distress?
   e.g. Debt Causes Arguments with Spouse
   Lack of Control Time consuming
3. Which of these problems would cause the most distress?
4. Have you sought help in the past for the compulsive shopping problem?
5. What kind of help did you seek?
6. Was it effective? (e.g., yes for the first few weeks).

Session 3: Intervention

Duration: 1 Hour
Objectives & Guidelines:

1. The daily diaries will be checked to make sure they are being filled out correctly, and any problems will be addressed.

2. Go through the results of the psychological tests with the participants, explaining what the results show.

3. Based on the behaviours evident in the daily dairies and revealed through the semi-structured interview the researcher will work together with the participants to define their compulsive shopping in concrete terms e.g. the amount of time and money spent, frequency and types of purchases.

4. Identify and agree on the specific goals that the participant wishes to achieve through the intervention program that are related to this target behaviour. It is the responsibility of the researcher to make sure that the goals being set are realistic and attainable. The goals may also focus on other aspects of the participant's life provided they are related to their compulsive shopping. For example if a participant is going shopping to relieve feelings of depression and loneliness, one of the goals may be to join a social club of some description.

   N.B: The goals and target behaviours are likely to be different for each participant as the reasons for compulsive shopping, the types of purchases made and the amount of time and money spent will be different.

5. Work through the handout explaining the principles of reinforcement, punishment and avoidance with regards to compulsive shopping, and its cyclic nature.

6. It is important that the researcher modifies the examples given in the handout so that they directly apply to the participant. As one of the main aims of this intervention program is to help the participants understand their behaviour in terms of the antecedents and consequences that trigger and act to maintain it. Being able to make sense of their shopping behaviour and places them in a stronger position to change it.

7. Work through the Changing Mood handout, outlining how your thoughts can determine the emotions you experience. Read through the sheet of Cognitive Distortions helping the participant to recognise the distortions that are present in their everyday thinking evident in their diary entries and in their conversations with the researcher.

8. Teach the psycho-educational technique of Thought Catching (cognitive restructuring) and how to apply this technique in their everyday lives. Choose a thought that has been written in the diaries as an example to work through with the participant. Help the participant come up with at least 5 rational responses.

9. The daily diaries of the participants will be photocopied and then returned to the participant so that the researcher can collate the baseline data.

Homework:
1. Complete the daily diaries
2. Apply thought-catching technique in situations that cause anxiety and/or depression, and write down the rationale responses used.

Session 3: Handout
Defining the Target Behaviour and Goals

Compulsive Shopping Defined
By looking at your diary with the researcher try to define your shopping behaviour in specific concrete terms. The information you include in the definition may involve the thoughts, emotions or situations that trigger you to go shopping, the amount of time and money you spend shopping, the frequency that you go shopping, the types of items you tend to purchase. Whether there are specific shops you tend to go shopping in, do you tend to go shopping alone or with friends? Do you use or return or hide the items bought?

Definition of Your Shopping Behaviour:

Goal Achievement:
Look at the above definition and work with the researcher to come up with the goals that you wish to achieve through the intervention. It is best if the goals include both qualitative change such as feeling more in control of your emotions, feeling better about yourself, feeling more relaxed and less anxious etc... as well as quantitative change which includes the amount of money spent, and the frequency of your shopping behaviour etc...
The Goals I Wish to Achieve:

How We Learn Behaviour

Reinforcement:
Your behaviour no matter how unpredictable or uncontrollable it may seem, is in fact controlled and to some extent can be predicted by looking at the situations, thoughts and emotions that surround the behaviour.

The problem with compulsive shopping (and other compulsive behaviours such as gambling or binge eating) is that the behaviour has been performed so often that it becomes almost automatic. When patterns of behaviour become so automatic little attention is paid to the cause-and-effect relationship that is maintaining the behaviour. This leads to the belief that the behaviour is uncontrollable and even illogical. For example you may make a deal with yourself not to buy things you do not need, and that afternoon of that very same day you find yourself buying something that you do not need simply because it was on sale.

Even though you enjoyed buying the item you walk away from the shop feeling happy about your purchase, it is likely that this positive consequence is short lived. The positive emotions from the shopping may be replaced by a feeling of anxiety about what your spouse will say or because you need to pay the phone bill this week and you have spent all your money. You wonder why do I do this?? Why do I continue to buy things I don't need? The answer to these questions can be found in role of reinforcement.

Reinforcement

Reinforcement *is a consequence that causes an increase in the performance of the behaviour on which it is contingent.*
This principle of reinforcement can be applied to the behaviour of compulsive shopping in more way than one.

The act of shopping is reinforcing in itself as it brings about pleasurable feelings. It is nice to buy nice things for others and yourself, it makes you feel good. However not everyone begins to shop compulsively just because they enjoy shopping. For example eating is reinforcing, in that it tastes good, it alleviates hunger and gives a sense of wellbeing, but not everyone develops a problem with binge eating or bulimia simply because they enjoy eating.

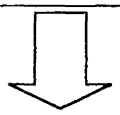
The problem arises when the reinforcing behaviour begins to be generalised to bring about pleasurable states from a number of different situations. Using food again as the example, people who suffer from binge eating do not eat food just to alleviate hunger. Instead food is used in a more generalised way, as a source of comfort and as an escape from negative situations and emotions.

It is more than likely that your shopping behaviour is being used as an avoidance technique to avoid dealing with problems or negative emotions (such as anxiety, distress, frustration, anger, sadness, and depression). By going shopping the situations causing these negative emotions are avoided and the negative emotions are replaced by the positive emotions associated with the shopping experience.

By looking at your dairy entries can you identify situations where you used compulsive shopping as a means to lift your mood and avoid negative emotions and situations? To take your mind off a situation that was causing you anxiety? Or making you feel depressed?

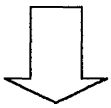
Model of Negative Mood and Compulsive shopping

Antecedents
List the antecedents you identified in your diary.



Buying Behaviour
Describe briefly what you normally do.

Describe how you normally feel when you go shopping.



Consequences
Describe how you feel after you have spent too much

What do you do to make yourself feel better?

CHANGING MOOD

Changing negative mood states using Cognitive Therapy techniques is based on the understanding that **your thoughts create your emotional experience**. Therefore, it is not so much the situation that you are in that determines your mood, but how you interpret that situation and how that interpretation reflects on your own self-image.

Listed below are some common cognitive distortions, read them carefully and try and identify some of the distortions that influence your thought patterns and your mood (you may want to refer to your diary entries).

10 Cognitive Distortions

1. ALL OR NOTHING THINKING: Is seeing things in black-and-white terms. If you view your performance as anything less than perfect, you view yourself as a total failure.
2. OVERGENERALISATION: Is when a single negative event is viewed as a never-ending pattern of defeat.
3. MENTAL FILTER: Is when a single negative detail is picked out and dwelt on exclusively thereby darkening the persons' whole vision of reality.
4. DISQUALIFYING THE POSITIVE: Is when positive experiences are rejected, insisting that they 'don't count' for some reason or another. This way the person can maintain a negative belief that is contradictory to their everyday experience.
5. JUMPING TO CONCLUSIONS: A negative interpretation is made even though there are no definite facts that convincingly support that conclusion. There are two types:
   A: MIND READER: Is when a person concludes that someone is thinking or reacting badly to them and yet will not make the effort to check it out (maybe that someone thinks you are stupid, or is looking down on you).
   B: FORTUNE TELLER ERROR: Is when a person anticipates that things will turn out badly, and is convinced that this prediction is already established in fact.
6. MAGNIFICATION OR MINIMIZATION: A person will magnify anything that they have done poorly way out of proportion, and shrink anything that they have done well so that it doesn't really count.
7. EMOTIONAL REASONING: A person will assume that their negative emotions necessarily reflect the way things are.
8. SHOULD STATEMENTS: People use 'shoulds' 'shouldn'ts', 'musts' and 'oughts' to get themselves motivated. However the very nature of these words make you feel pressured and resentful and guilty and will have a negative effect on your moods.
9. LABELING AND MISLABELING: This is an extreme form of overgeneralization, instead of the person describing their error they attach a negative label to themselves "I am a loser" instead of "I made a mistake". Mislabelling involves describing an event with language that is highly coloured and emotionally loaded.
10. PERSONALISATION: When a person sees themselves as the cause of some negative external event which in fact they were not primarily responsible for.

Thought Catching

This is an exercise to help train you to recognise cognitive distortions and combat them with realistic responses, thereby changing your mood in a positive way.
When you experience a negative emotion write it down in the emotion column in the table below. Then try and 'catch' the thought that started the emotion. For example if you were feeling depressed, you would try and remember what thoughts were running through your head that led you to feel that way, like 'I can't do anything right'. Once you have written the thought down, try and work out which cognitive distortion that thought fits into and right that down underneath. Then in the next column write down as many realistic responses that you can think of to combat that negative thought. In the final column right down the emotion that you are now experiencing. If you still feel bad by the time you reach the outcome column, go back to the thoughts column and catch new thought (it is likely to be a variation of the original) and repeat the process with this thought.
NB: Note that some negative emotions are valid and do not need to be reasoned away using thought catching, but rather other techniques such as problem solving and assertive action are called for. An example would be someone with a partner who physically or emotionally abuses him or her, their emotion is anger and their thought is 'this guy is no good for me'. Clearly in this case thought catching is not the technique required!

By looking in your daily diary, find a thought that led you to feel a negative emotion and right the emotion and thought down below. Work with the researcher to first label the cognitive distortion (e.g. overgeneralization) and then to come up with 5 realistic responses to combat that thought.

Emotion	Thoughts	Realistic Response	Outcome

Session 4: Intervention

Duration: 1 Hour

Objectives & Guidelines

1. Review the daily diaries and discuss any possible problems. Photocopy the diaries to collate data and then return them to the participants.

2. Read through the handout on active planning with the participant and help them write a plan out for their next day.

Home Work:

1. Continue with the daily diary entries
2. Continue with the thought-catching technique taught in Session 3.
3. Begin active planning. Write a plan of action for each day.

Session 4: Handout
Active Planning

Today's session is on Active Planning. This involves planning tasks for the day and then working actively to achieve them. People who do not plan what they are going to do for the day generally find that they do not accomplish what they need to. On the other hand others will plan extensively and even make plans about how they are going to do their plans and still accomplish very little.

When small tasks do not get done they tend to add together with today's tasks and become quite overwhelming. It is at these times that people generally find other things to do (like shopping or eating) however after these other activities are done the original task still sits there uncompleted. For others rather than going out and finding other activities to take their mind off things, the size of the task zaps their motivation to do anything at all and they can end up staying in bed all day.

Important Things to Remember

1. **Motivation follows Action:** Some people decide that they will do things when they feel motivated. But the feeling of motivation comes **after** you have performed **positive action.** You may think I will begin exercising when I get motivated. But you will begin to get motivated when you start exercising. It may involve you taking walks around the park for a week before you begin to feel motivated to go.
2. **Action is Rewarded:** When you make positive steps towards your goals you will find it rewarding. Often when people begin an unpleasant task like doing a big pile of dishes, they will begin to feel happy about the task half way through because they can see their progress. Then when the job is completed a real sense of satisfaction comes from seeing the job done and having a clean kitchen to show for it.
3. **Little Steps are More Fun:** Make sure you do not take an *all or nothing* approach to your tasks. Break the big tasks into little ones and realise that the completion of each little step is a success in itself.

For example the task may be 'The kitchen needs to be cleaned' and you may see that as the **WHOLE** kitchen! This means dishes done, oven cleaned, benches sprayed and wiped, sink scrubbed, floors swept and then mopped. I don't think anyone would be keen to start this task!

Instead make each of those elements of a clean kitchen a task in themselves, you may even want to break them down even further e.g. washing the dishes is one task, drying them is another. REMEMBER TO KEEP IT SMALL AND SIMPLE.

4. **Tasks Will Seem Bigger Until You Start Them:** Even when you have broken your big tasks into lots of little manageable ones they will probably still look just as unappealing until you START them.
5. **Balance Your Tasks:** Make sure you balance your tasks with things that you find pleasurable, going out with a friend, reading a book, taking a walk, visiting an art museum. Try and find pleasurable things to do that won't involve shopping.
6. **Plan Ahead:** Write down a plan of action in advance for the times that you find difficult. For example you may find yourself more restless or bored in the afternoons. Plan ahead of time (either the night before or early that morning) interesting things that you can do. It is best that you don't wait until you are bored before you plan what you are going to do as it is harder to get motivated in those times.
7. **Be Reasonable:** Try not to list so many things to do for a particular day that there is no way you can do it all. It will only make you feel worse at the end of the day to see the 20 things you did get done swamped by the other 100 tasks that you listed.
8. **Remember Your Goals:** Remember the goals you listed in the previous session and start taking small steps to achieve them.
9. **Action, Action, Action:** Remember this is all about action. Do not expect to feel better just because you have planned an endless list of things to do for the day. You will feel better when you ACTIVELY do those tasks.

Below is an example of the Active Planning Sheet. Write down an hour by hour plan of what you would like to get done for the day, include simple tasks such as getting dressed, eating lunch as well as more difficult tasks such as working on a paper, paying bills, writing letters. When you have finished the task put a tick in the completed column. And keep a record or the actual time taken to do the task. Then give yourself a rating out of five (1 = easy, 5 difficult) for difficulty of the task and how much you enjoyed doing the task or completing it (1= little or no enjoyment, 5 = enjoyed a lot).

Date:

Time	Activity	Completed	Time Taken	Difficulty	Pleasure
7-7:30	Get dressed		30mins	1	2
7:30-8	Organise kids for school.		45mins	5	4
8-9	My Time, eat breakfast and relax		35mins	1	5

NB: Just because a certain activity is generally perceived as quite easy to achieve like getting dressed doesn't mean that it is for everyone. It is quite acceptable to put a 5 for getting dressed if this is the hardest part of your day. Often when people are overwhelmed with the things they have to get done during the day, just getting out of bed and getting started can be extremely difficult.

Beat Procrastination!

Even though you have planned your tasks for the day very carefully you may still find it difficult to get started. This could be because of the thoughts you have about the doing the task. To help deal with procrastination we will build on the skills you learnt last week involving *Thought Catching*.

Write down the task that you have been putting off, making sure that it is not too big and has been broken into easier steps. Now write in the next column how hard you predict each of the steps will be using the same 5-point scale (1=easy, 5=difficult).

Then in the next column write how satisfying you think the task will actually be again using the 5-point scale. Now once these predictions have been completed, go ahead and perform the first step of the task and then rate how difficult you found the task and the amount of pleasure that you gained from it.

Date	Task	Predicted Difficulty	Predicted Pleasure	Actual Difficulty	Actual Pleasure
3 Sept	Assignment from Work	4	1	2	3

If you can't seem to complete the task above, try using the *Thought Catching* skills you learnt last week to catch the thoughts that automatically run through your mind when you think about that particular task and challenge each one as we did in last weeks session.

Some of the thoughts may be "I am too tired", "I won't enjoy it" "I haven't got the motivation today", "It can wait until tomorrow" etc...

Emotions	Thought	Response	Outcome
Depressed	I can't be bothered. It can wait until tomorrow.	Things are always hard until you start them. I probably won't feel like doing it tomorrow either I can begin the task and if it is too much I can stop. I will feel better when it is done.	Feel better about starting the task.

Session 5: Intervention
Problem Solving

Duration: 1 hour
Objectives & Guidelines:
1. Review and photocopy daily diaries

2. Review last weeks thought catching and active planning homework. Discuss any problems.

3. Teach the new psycho-educational technique of active planning. Work through the handout and then help the participant apply the problem solving skills to a problem in their lives, preferably a problem that is playing an active role in their shopping behaviour.

Home Work:
1. Continue filling out the daily diaries
2. Continue the thought-catching and active planning techniques
3. Implement the solution that you and the researcher chose to solve the problem discussed during this session.

Session 5: Handout
Problem Solving

The rationale for teaching problem solving skills in this session is based on evidence showing a link between anxiety and depression and an inability to solve everyday problems. Research has found that training in problem solving skills can produce beneficial effects for people with depression and anxiety and improve a person's functioning in everyday life.

Identifying the Problem

Before a problem can be solved it must first be identified and acknowledged. It is normal and inevitable to encounter problems and obstacles in our everyday lives. The fact that you have problems does not mean you are managing your life badly or that your life is out of control. However it may feel like this if your daily problems are not being identified and dealt with effectively.
To be an efficient problem solver it has been suggested to follow the following steps.
1. Accept the fact that problematic situations are normal in everyday life, and that it is possible to cope with most of these situations effectively.
2. Recognise problems when they occur.
3. Resist the tendency to respond to the problem either on first 'impulse' thereby reacting automatically, or by passively avoiding the problem by 'doing nothing'.

Problem Definition and Classification

Most of life's problems present themselves in a messy, vague or ambiguous form, and they lack the necessary facts and information needed to tackle the problem effectively. This step of problem definition and classification is designed to help you put your problem into manageable concrete terms.

Define all the aspects of the problem
Instead of making a broad statement to describe your problem, write it down using clear concrete terms.
Classification: Involves separating the relevant information from the irrelevant information, identifying the primary goals and specifying the major problem and sub-problems.
For example instead of saying 'I have too many bills pay', write down exactly what bills you have to pay (e.g. phone, power, rent, speeding ticket), the amount you have to pay for each of them and the date that each one is due. Then write down the amount of money that you have available in your bank, and when your next pay is due.

Now that your problem is defined in manageable terms, it is possible to order the problem according to priority. For example giving priority to the bills that are overdue, followed by those that are not due until later in the month.

NOTE: It is likely that you have multiple problems on your mind involving the different aspects of your life (work, family, finance, and friends). To help minimise feelings of anxiety and depression it is important to focus on one problem at a time, and breakdown the big problems into smaller manageable ones.

Generation of Alternative Solutions

During this phase the aim is to brainstorm and generate as many alternative solutions to your problem as possible. List all the solutions that you can, even if they don't seem that helpful. Remember the rules of brainstorming are

a) Criticism of ideas are not allowed,
b) Creativity and originality is great (it is easier to tame down an idea rather than think one up.
c) Quantity breeds quality (the greater the number of ideas the greater the likelihood of useful ideas.
d) Improving previous ideas and combining ideas are sought.

For Example: Using the same problem of bill payment described above, some alternative brainstorming solutions may include...

1. Pay only the bills that are overdue
2. Don't eat for a month
3. Make arrangements with the Phone Company to pay the phone bill in small weekly payments.
4. Put off going to the hairdresser until next month.
5. Pick up a part time job
6. Borrow money off a family member
7. Ignore the bills until next month when I should have more money
8. See the bank for a temporary loan
9. See a budget advisory clinic
10. Write bad checks and worry about it latter when they bounce.

Decision Making

Examine the list of solutions created from the brainstorming and eliminate those that are clearly not acceptable (for example not eating for a month, and writing bad

checks). Perhaps other seemingly plausible solutions like picking up a part-time job have to be discarded because you may already have a full-time job and a part-time job and you would like to keep your weekends free to spend with your children.

Now that you have a revised list of alternative solutions, examine each solution in terms of short-term and long-term effects. This will allow you to select the alternatives that seem most likely to provide the best solution.
For example borrowing money off a family member may have great short-term effects in that your bills are paid. But perhaps this alternative will have bad long-term effects on your relationship if you are unable to pay back the family member within a specific time period.

Solution Implementation and Verification

Once you have chosen a course of action and carried it out, it is important to evaluate its effectiveness so that self-correction is possible. If you have all your bills paid and have enough money to live off it is possible to say that your solution worked. If however you have paid no bills and are still struggling financially it is evident that the solution of choice has not been effective in solving your problem. At this point you can choose to select another solution from the list or generate some more alternatives to choose from.

Session 6: Intervention
Budget Advice

Duration: 1 ½ Hours
Objectives & Guidelines:

1. Review daily diaries and photocopy last weeks entries.

2. Review the homework from the previous week and discuss any problems.

3. The participants will meet with a professional budget advisory person and together they will work out a budget plan (spouses/partners are encouraged to attend this session).

Session 7: Intervention
Emotional Writing
Relaxation Training
Sleeping Techniques

Duration: 1 ½ Hours
Objectives & Guidelines:

1. Explain the rationale behind emotional writing, work through the emotional writing handout and then give the participant 10 minutes alone to write about a situation or experience that has caused them great distress. Make sure the participant knows only they will read what they write, no one else. When they have finished writing the researcher may want to discuss with the participant how they are feeling. The researcher should again explain that although this type of

writing is very beneficial in the long run people generally feel worse straight after this type of emotional writing.

2. To help the participants leave this session feeling more relaxed and positive the researcher will follow the writing task with progressive relaxation training.

- First work through the handout explaining the rationale behind progressive relaxation, what is involved and some common experiences that they may experience with the training (e.g. cramps, dizziness etc..).
- Go through the 16 different muscle groups that will be tensed and relaxed and model for the participant how this will be done.
- Make sure the participant can identify these muscles and are able to tense and relax them in a satisfactory manner.
- The researcher should provide something soft for the participants to lie on such as a small mattress and a small pillow.
- Make sure the participant is comfortable and has removed shoes, watch, jewellery and/or glasses.
- Explain to the participant that it is important to remain focussed on the muscle group that is being worked on. And that the muscle tension will be held for about 4-6 seconds (except a shorter period in the feet due to cramps). Stress the importance of the tension being released all at once. Explain that the relaxation period will be between 10-20 seconds.
- The researcher will explain that while the participant is doing the progressive relaxation that they will not be watched, as the researcher will be reading off a set script. So that the participant can feel less self-conscious and therefore able to become more relaxed.
- Where possible darken the room by turning lights off and pulling the curtains. Place a sign on the door stating "Research in Progress" to avoid interruptions.

3. Once the progressive relaxation training is complete read through the handout on 'Techniques for Better Sleep'.

Researchers Copy
Progressive Relaxation Training

Lie in comfortable position and close your eyes so you won't be distracted...

Relaxation of Hands and Arms

Right hand and Arm:
We will begin training with the muscles in your right hand and forearm.
Tension: I would like you to focus all your attention on these muscles and tense them by making a tight fist now. You should be able to feel the tension in the hand, over the knuckles and up into the lower arm (wait 5-7 seconds).
Relaxation: O.K and relax. Just let these muscles go, noticing the difference between tension and relaxation. Focusing on the feeling in this muscle group as it becomes more and more relaxed. Let the fingers of your right had become loose, and observe the contrast in your feelings between the tension that was there a moment ago and the greater sense of relaxation now.
T: Once more clench your right fist really tight ...hold it, and notice the tension again....

R: Now let go and relax; let your fingers straighten out....and notice the difference once more.

Left Hand and Arm
O.K we'll leave the right hand now and attend to the left hand...
T: Clench your left hand into a fist....very tense, very tight....clench your fist tighter and notice the tension...
R: And now relax. Again notice the contrast. Let your fingers relax and straighten and allow the tension to drain out of your hand and arm.
T: Again clench your left hand into a tight fist, and feel the tension across your knuckles and in your forearm.
R: And relax, let go of all the tension all at once, let the muscles in your hand relax and across your forearm, let the muscles continue to become more and more relaxed.

Right Bicep:
Now we will leave both hands comfortable and relaxed and move to the right bicep.
T: Bend your arm at the elbow to tense your right bicep, the right upper arm. Tense them harder and study the tension.
R: O.K let your arm relax and feel that difference again between tension and relaxation – the absence of tension. Let the relaxation develop.
T: Once more, tense your right bicep, hold that tension and observe it carefully...
R: Now straighten the arm and let the tension go, let your arm move in a comfortable position and let the muscles become more and more relaxed.

Left Bicep:
All right, now we'll move to the left upper arm, and the left bicep...
T: Tense up the upper arm by bending the your left arm at the elbow, very tight, very tense... Feel the tension in the bicep and the upper arm...this is muscle tension.
R: All right, now release the tension. Let your arm return to a comfortable supported position and notice the relaxation... a greater sense of relaxation in the entire left upper arm.
T: Now once more, tense the left upper arm right now, very tense, very tight...and notice the tension. This is how tenseness feels.
R: Now relax the arm, letting the tension be replaced by relaxation and let your arm move to a comfortably supported position.

So right now you can notice the increased sense of relaxation in the right hand... and the fingers of the right hand... and the right forearm and also the right upper arm...Likewise you can notice the increased relaxation in the left hand, the fingers of the left hand... the left forearm and the left upper arm...very relaxed in both hands and both arms.

Relaxation of the Forehead, Eyes, Facial Area, Neck and Shoulders.

Now we'll leave both the hands and arms comfortably supported and shift our attention to the area around the head.

Forehead
T: We'll start with the forehead. In order to tense the forehead, I'll have you wrinkle up your forehead right now. Wrinkle it tighter...like you are frowning...tense and tight.

R: Now relax the forehead and smooth it out. Picture the entire forehead becoming smoother as the relaxation increases.
T: Now, frown once more and wrinkle your brows and study the tension...very tight.
R: Now let go of the tension and smooth out your forehead once more.

Eyes
Now we'll move to the eyes
T: Close your eyes tighter and tighter...feel the tension.
R: Now relax your eyes; keeping your eyes closed, but comfortably relaxed and notice the sense of relaxation.
T: All right, once more, close your eyes really tight and notice the tension...tight and tense.
R: And now relax, let the tension disappear and be replaced by a greater sense of relaxation.

Jaws:
While your eyes are closed and much more relaxed, we'll move our focus onto the jaw.
T: Bite your teeth together, study the tension throughout the jaws
R: All right, relax your jaws...notice the relaxation all over your face...your forehead...your eyes, lips and jaws.
T: Now once more bite your teeth, clench your jaws and notice the tension that creates.
R: O.K, now relax the jaws and the entire facial area. Let the relaxation proceed on its own to cover the forehead and the eyes and the jaws, the entire facial areas.

Neck:
Now we will attend to your neck muscles.
T: Press your head back as far as it can go and feel the tension in the neck...tense and tight.
R: Now let your head return forward to a comfortable position, and notice the relaxation. Let the relaxation develop further.
T: Once more, press your head back and notice the tension.
R: All right now relax the neck and let your head return to a comfortable position.

Shoulders:
Now, we'll move to the shoulders.
T: Shrug your shoulders, right up. Hold the tension.
R: Drop your shoulders and feel the relaxation...let the relaxation increase in the neck and shoulders.
T: Shrug your shoulders again. Feel the tension in your shoulders and in your upper back.
R: Now drop your shoulders once more and relax. Let the relaxation spread deep into the shoulders...and your forehead and eyes and the entire facial area.

Relaxation of Chest and Stomach

Now we'll move from the head and shoulders to your upper body. Breathe easily and freely in and out. Notice how the relaxation has increased across your body...As you breathe comfortably, just feel that relaxation.

Chest
T: Now inhale deeply and hold your breath. Study the tension.
R: Now exhale, let the walls of your chest grow lose and push the air out automatically. Continue relaxing and breathe freely and easily. Feel the relaxation and enjoy it.
T: Now breathe in deeply and hold it again.
R: That's fine, breathe out and appreciate the relief. Just breathe normally. Continue to relax your chest and let the relaxation spread to your shoulders, your neck, your facial area and your arms. Merely let go and enjoy the relaxation.

Stomach
Now lets pay attention to your stomach muscles.
T: Tighten your stomach muscles, make your abdomen hard. Notice the tension.
R: And relax. Let the muscles loosen and notice the contrast.
T: Once more, press and tighten your stomach muscles. Hold the tension and study it...and relax.

Relaxation of Feet and Legs.
All right, we'll now move to your legs and feet.

T: To tense up your legs and feet, press your feet and toes downwards, away from your body, so that your calf muscles become tense (To avoid cramps make this brief).
R: Alright now relax, allow the relaxation to proceed on its own.
T: Now, once more press your feet and toes downwards, away from your face, so that your calf muscles become tense. Study that tension.
R: O.K, now relax your feet and legs.

Breathing
Now you can become twice as relaxed as you are by taking a really deep breath and slowly exhaling. Take a long deep breath and let it out very slowly, using that method to become as relaxed as you would like to be. Once more take a deep breath and let the relaxation flow over your body...relaxing your hands and arms, your facial area...the muscles in your neck and shoulders...your stomach...and both legs and feet.

Termination of Relaxation
In a moment, I'll count backwards from 3 to 1. Use that countdown to prepare yourself to become more alert and refreshed. When I have reached 1, you can open your eyes and begin to slowly sit up. Three.....Two.....One.

Session 7: Handout 1
Emotional Writing Task

It has been shown in a number of studies that writing about personal events (especially traumatic, upsetting and stressful ones) can have a beneficial effect both psychologically and physically. The act of writing about a traumatic event helps individuals to translate the event into language. Once encoded linguistically, individuals can more readily understand, find meaning or attain closure from the

experience. Studies have also shown that writing about disturbing events can improve ones immune function and general health.

The topics that can be written about can be anything that is upsetting you at the moment or perhaps something from your past. This writing task can also be useful when you feel in a general state of sadness or anxiety but have not idea why, in such cases writing in this way can help to make sense of your emotions and help find out why you are feeling this way.

Today's Task

For this writing task today please write about the most upsetting or traumatic experience of your life. Don't worry about grammar, spelling, or sentence structure. In your writing, I want you to discuss your deepest thoughts and feelings about the experience. You can write about anything you want but it should be something that has affected you very deeply.

The effectiveness of writing about personal events can be influenced by the following factors.

1. Generally the more distressing and upsetting the experience that is being written about is, the more beneficial the task.
2. Those that write both their emotions as well as their thoughts about the experience tend to get better results (more insight) than those who write only about their emotions.

Homework

During the next few weeks, take some time out to write about the things that may be upsetting to you. These can be things that have happened a while ago or can be things happening in your life now. This task of free writing can also be helpful in times when you are not sure what it is that is upsetting you, in such times the act of writing itself can bring insight.

Session 7: Handout 2
Progressive Relaxation Training

The techniques that we will be using to train relaxation are based on the Progressive Relaxation Techniques first devised in the 1930's by a physiologist named Jacobson. Over the years these techniques have been modified in order to make them easier and more effective. Progressive relaxation training consists of learning to sequentially tense and then relax various groups of muscles all through the body, while at the same time paying very close attention to the feelings associated with both tension and relaxation. This training will help you recognise the presence of tension when it appears in your everyday life, and will give you the skills to be able to relieve that tension.

It is important to stress that the successfulness of these techniques are dependent on you practising these techniques at home, without regular practice the procedures learnt today are of little use.

So Why Produce Tension?

It may seem strange to produce tension when the goal is become relaxed, but here are some of the main reasons for this.

1. By tensing the muscle and then all at once releasing it you will learn to produce larger and more noticeable reductions in tension, that will go far below your normal level of tension. You can think of it in terms of a pendulum hanging motionless in a vertical position. If we want to swing it to the right we could push it quite hard in that direction. But it would be much easier if we began by pulling the pendulum in the opposite direction and then let it go. Because it would then swing well past the vertical point and continue to move in the direction we wanted it to go. Therefore by tensing the muscle groups prior to letting them relax is like giving ourselves a "running start" toward relaxation through the momentum created by the tension release.

2. Tensing the muscles first gives you a good chance to focus your attention on that muscle and become clearly aware of what tension really feels like in each of the muscle groups. It will also help you detect tension and deal with it in everyday life.

3. The tensing procedure will make a vivid contrast between tension and relaxation and will give you an excellent opportunity to directly compare the two and appreciate the difference in the feeling associated with each of these states.

Things to Remember

1. In this training session we will be dealing with 16 muscle groups, but as you practice these techniques and become more efficient in the following weeks you will be able to reduce this number significantly and still get the desired result.

2. It is best to do this training whether here or at home in comfortable clothing, with your shoes, watch and any jewellery and/or glasses removed.

3. This training can be done either lying down on a bed, on the ground with a towel and pillow, or in an armchair. What is important is that your whole body is supported, so that you can relax your muscles without loosing your position or falling out of the chair.

4. It is also important that when the cue to relax is given that you let the tension go all at once. Don't let the tension go gradually as this defeats the purpose of tensing the muscles in the first place.

5. Do not move around during the session unnecessarily; however you may feel free to move in any way that helps you maintain a comfortable position.

Common Experiences

Some common experiences are written below and hopefully having this knowledge before we begin should prevent them from taking you by surprise and making you feel uneasy.

- A feeling of light-headedness.
- Cramp in certain muscles: these should be stretched out when they occur and less tension should be used in that muscle group during that particular session.
- Ticks: These may seem strange because they usually only occur while we are asleep but they are perfectly normal and are a sign that deep relaxation is occurring.
- Some people fall asleep during progressive relaxation training. This should be avoided and can be avoided by remaining focussed on the sensations of tension and relaxation in the muscle group you are working on.

Remember to practice these techniques at home during the week.

Techniques for a Better Sleep

The techniques discussed below are aimed at changing the cues that surround your sleeping behaviour. Some sleep rituals facilitate falling asleep while other rituals may interfere with your sleep onset e.g. watching TV, reading, eating and/or worrying in bed.

Analyses suggests that it is possible to develop treatment for insomnia by separating the cues for falling asleep from the cues for other activities thereby strengthening the bed as a cue to sleep and weakening it as a cue for other activities that may interfere with sleep.

Read the rules for better sleep written below and start to practice them over the next four weeks. Remember you may not experience the results straight away, but it is important to persevere with the techniques as it may take a while for the cues around your sleeping behaviour to change.

1. Lie down intending to go to sleep only when you are sleepy

2. Do not use your bed for anything other than sleep. That means do not read, watch TV, eat or worry in bed. Sexual activity is the only exception to this rule.

3. Go through the progressive relaxation training, tensing and relaxing each muscle group, taking easy slow breaths.

4. If you find yourself unable to fall asleep, get up and go into another room. Stay up as long as you wish and then return to bed when sleepy. If you do not fall asleep within 15mins get out of bed again and go into another room. Remember the goal is to associate your bed with falling asleep quickly. Continue to repeat this step as many times as necessary until you fall asleep.

5. If it is worry that is keeping you awake, try writing down what it is that is worrying you and come up with some possible solutions (while you are in the

other room) or do your "thought catching". If it is the next day that you are thinking about, write down a plan for the next day with a list of all the things you need to do. The aim is to deal with whatever it is that is keeping you awake so that you can go to bed and sleep.

6. Set your alarm and get up at the same time every morning regardless of how much sleep you got during the night. This will help your body acquire a consistent sleep rhythm.

7. Do not nap during the day.

Session 8: Intervention
Assertiveness

Duration: 1 Hour

Objectives and Guidelines

1. Check daily diaries, photocopy the entries and return them to the participants
2. Review last weeks' homework; emotional writing, relaxation training and sleep techniques. Discuss any problems or queries that the participant may have regarding this homework.
3. Read through the handout on assertiveness with the participant and the examples of different the behavioural responses.
4. Discuss the different examples and pay particular attention to the steps taken in the assertive response.
5. Ask the participant to choose an aspect of their life that they are not happy with; because they feel that they are be taken advantage of, or that their feelings are not being taken into consideration or where they feel others are blocking or thwarting their goals.
6. Work with the participant to devise an assertive plan of action. Outlining each step of the assertive response. Making sure that they have expressed their feelings, wants and needs in a calm and rational way.
7. Encourage the participants to take this assertive action during the week. If they feel that they can't or that they are not ready discuss why they are feeling this way and work out ways to deal with these problems.

Session 8: Handout
Assertiveness

What does being assertive mean?

Being assertive is about respecting your-self and others. It is about standing up for your own rights, without infringing upon the rights of others. Being assertive means that you honestly state your feelings without denying your own right to express yourself or denying the rights of others to be respected. If you are assertive you let people know what you think and have a good chance of getting what you want and need.

Assertive behaviour is very adaptive as it is self-enhancing, generates positive feelings toward one-self and others and leads to smooth interpersonal relationships.

What do you need to be assertive?

1. **Know Your-Self:**

To be assertive you need to be able to express yourself clearly, directly and appropriately. This can only be done effectively when you know what it is that you believe, think and feel and accept these views and feelings as valid and important.

Having an accurate self-perception is not always easy, however the skills that you have learnt in the previous sessions (e.g. diary keeping, thought catching, emotional writing) have been developing and improving the accuracy of your self-perception and awareness.

2. Take Responsibility:

Being assertive means taking responsibility for your life and your life choices. Taking responsibility means that you can't blame other people or circumstances for what happens to you. When you are responsible for your own behaviour you can begin to make important decisions to change unpleasant situations.

Being assertive also means taking responsibility for your feelings. As we have learnt in previous sessions the way we feel is often a reflection on how we perceive a certain situation and think about it (remember the "though catching" task). We also learnt that our emotions can change when we choose to challenge those thoughts with "truth" statements.

3. Decision Making

Taking responsibility for our thoughts, emotions and behaviour places us in a position to make decisions about them and allows us to change aspects of our life that we are not happy with.

Other Types of Behaviour

Non-Assertive Behaviour:

Being *non-assertive* means you do not respect your right to express your ideas, needs, wants, feelings and opinions. People who are non-assertive do not like to take assertive action because is causes fear, anxiety and/or guilt. Being non-assertive may allow you to avoid a conflict in the short-term, but because no one knows how you feel you probably won't get what you want or need and may feel as though no-one respects you, or you may get angry with people for taking advantage of you.

Aggressive Behaviour:

Assertiveness should not be confused with aggressiveness. *Aggressiveness* is the tendency to display offensive, hostile behaviours against others, without regard of their rights. Aggressiveness is not an adaptive behaviour because it generates negative feelings such as guilt, remorse, and fear of consequences and alienation. It also causes constant confrontation with others and leads to shallow emotional ties.

Example: Illustrating the different types of behavioural responses.

Situation:

Barry is an easygoing file clerk, works in an office with 12 other file clerks. Each clerk has responsibility for filing a prescribed number of records each day. Barry because he is either more conscientious or more efficient than his fellow workers is able to file about a third more records each day than the others. Two of the other

clerks, Benjamin and Karl, have become accustomed to bringing some of their work to Barry stating that they "just can't get to it". This irritates Barry because it adds to his work and he doesn't like Benjamin and Karl's lazy attitude, particularly in view of the fact that he overheard them joking about how clever they were at getting Barry to do their work. Resentment has been building in Barry for some time and now has reached the point where it is seriously bothering him.

Non-assertive Response:
Barry continues to work at his usual place, doing the extra work in addition to his own, and not saying anything to either Benjamin or Karl. He tries to rationalise his behaviour by saying to himself that he doesn't really mind the extra work and that in any case, he gets paid to work eighth hours a day and that's what he is doing. But this and the other rationalisations don't work that well. As time goes by, Barry looks more and more upset. Benjamin and Karl suspecting the truth, one day ask him if their adding to his work bothers him. Barry can't bring himself to express his true feelings and laughs off the question. Needless to say, Benjamin and Karl keep "sharing their work" with Barry.

Aggressive Response:
Barry ponders his situation over. The more he thinks about it, the more upset he becomes with the fact that he is doing more than his fair share. Resentment builds up and turns into hostility toward Benjamin and Karl. But he doesn't say anything to indicate his displeasure and keeps working and sulking. Finally, on a day that Barry feels particularly angry, Benjamin brings over some records and asks Barry to file them for him. Without any warning, Barry explodes "You no-good lazy ****!" Barry screams, "I've done your damn work too long, and am tired of it". Benjamin's feeble attempt to find out why Barry is so mad seems only to infuriate him more. All Barry wants is to get his hostility off his chest, he continues to yell at Benjamin and then starts with Karl until, completely exhausted and still shaking he suddenly stops. Benjamin and by this time Karl look at him in stunned disbelief. "Why haven't you said something about this earlier?" they ask when they can finally put a word in. Barry stands there feeling awkward and not knowing what to say.

Assertive Response:
After working under the above circumstances for a brief period of time and realising that Benjamin and Karl will not change, Barry decides to put an end to a situation he finds intolerable. He chooses a time when he, Benjamin and Karl are alone and without interruptions, he begins "It is not that I don't enjoy working with you, because I do. But I must tell you that I am irritated with having to do all of your work as well as my own." He goes on to say that he feels it is only fair that they do their share of the work, just as he does his. Benjamin and Karl appreciating Barry's forthright manner, say that they see his point and understand how he feels. "Good," replies Barry, "I am sure that you will also agree with me when I say that from now on I will not be doing any of your work." Benjamin and Karl reply that they do and that in the future they will do their work and leave Barry alone to do his. They part, each feeling comfortable with the way the situation was handled.

Things to Notice
1. The aggressive response in the second example is not the result of Barry just being an aggressive person. But rather being a non-assertive person who had just had

enough! If a non-assertive person continues to accept a situation that they are not happy with, he/she runs the risk of one day reaching breaking point and acting in a similar way to Barry in this aggressive example.

2. Notice in the assertive response example the steps that Barry took to explain his point of view and get what he wanted. 1) He chose a suitable time where they could meet on his terms without interruptions. 2) He started his conversation by getting Benjamin and Karl on side by saying "It's not that I don't enjoy working with you, because I do." By doing this he has removed the defensiveness of Benjamin and Karl because obviously whatever complaint he is about to make is not personal but rather professional. Barry's manner is calm and rational. 3) Barry explains the problem and how he feels in a calm manner. 4) Barry states clearly what it is that he wants Benjamin and Karl to do in the future to relieve this problem.

Today's Task

1. Think of areas of your life that you are not satisfied with. For example areas in your life where you think you are being taken advantage of, where your feelings are not being taken into consideration, or where you feel others are blocking or thwarting your goals.
2. Choose one of these areas to work through in this session (you may want to start small, as the homework is acting assertively on this problem).
4. Define the situation and your thoughts and emotions. Include also what you would like to see happen in that situation (stating your needs/wants).
5. Work out an assertive plan of action, that will involve expressing your feelings and clearly stating your needs/wants to the person/people involved in the situation. Making sure it is done without aggression and without non-assertive avoidance tactics (e.g. getting someone else to talk to the people involved).

Homework

Put into action the assertive plan worked out in today's session.
Look at the areas of your life that you listed above as not being satisfied with and in the same way that we did today work out assertive ways to address these problems.

Session 9: Intervention Program Summary Maintenance Program

Duration: 1 Hour
Objectives & Guidelines:

1. Check daily diaries, photocopy the entries and return the diaries to the participants.

2. Check last week's homework, of the participant carrying out the assertive plan of action devised during session 8.

3. Read through the program summary handout, outlining every intervention session of the psycho-educational intervention program.

4. Work through the maintenance program handout to help the participant devise a plan that will help to continue their progress until they meet with the researcher again in one months time.

Session 9: Handout
Program Summary
Session 3: Reinforcement

Reinforcement

In session 3 we learnt about the role of **Reinforcement** and **Avoidance** on maintaining behaviour. W learnt how *reinforcement* increases the likelihood of the behaviour (that was reinforced) being repeated in the future. This principle was discussed in relation to your shopping behaviour. Together we identified the types of situations, thoughts and emotions that led you to go shopping, and how the shopping behaviour was reinforced by writing down a definition of your shopping behaviour and the goals that you wished to achieve.

We also learnt a technique to help change negative mood states (such as anxiety or depression) called **Thought Catching**. This technique is based on the principle that emotions are often the result of how we perceive and think about situations. Therefore if we can change the way we think about a situation by using rational responses to the negative thought we can often change our emotions.

Session 4: Active Planning

Active planning involves planning realistic tasks for the day and working actively to achieve them. It involves breaking down large tasks into smaller and more manageable ones. There were a number of principles that were taught to help you succeed in your active planning. Some of them are listed below,

1. **Motivation Follows Action**: The feeling of motivation comes after you have performed positive action.
2. **Tasks** will seem bigger until you start them.
3. **Balance Your Tasks**: Make sure you balance your tasks with things that you find pleasurable.
4. **Plan Ahead**: Write a plan of action in advance for the times you find difficult. For example you may find yourself getting more restless and bored in the afternoons.
5. **Be Reasonable**: Don't plan so many things that there is no way you could complete it all.
6. **Action!** Do not expect to feel better about things because you have planned an endless list of things to do for the day. You will feel better when you actively do them.

Session 5: Problem Solving

Problematic situations are normal in everyday life. However learning how to effectively face and deal with these problems helps to alleviate feelings of depression and anxiety often caused by these problems. The steps of problem solving are outlined in 5 steps.

1. **Identify the Problem**:

2. **Define the Problem**: Instead of making broad statements to describe your problem write it down using clear concrete terms. E.g. "I have to pay the phone bill $87.50 on the 10 November and the power bill of $110 on the 27 November." Instead of "I have too many bills to pay."
3. **Generate Alternative Solutions**: Brainstorm and write down a list of all the possible ways that you can think of to deal with the problem.
4. **Decision Making**: From your brainstorming list, start eliminating the options that are not plausible, examine the remaining options in terms of long-term and short-term goals and select the option that will give you the most desirable outcome.
5. **Solution Implementation**: Once you have chosen your plan of attack, carry out the cause of action and then evaluate its effectiveness. If it was not effective you can choose another option from your list, or generate some more alternatives to choose from.

Session 6: Budget Advice

This session was designed to introduce you to some of the principles behind designing a budget that meets your needs and priorities. To gain a personalised budget designed by a professional budget advisor you were invited to contact The Citizens Advice Bureau (Budget Advice) phone: 366-3422

Session 7
Emotional Writing
Relaxation Training
Sleep Techniques

Emotional Writing: Research has shown that free-writing about emotional and personally traumatic events has both psychological and physiological benefits. The effectiveness of the task is generally increased if the experience written about is personally distressing, and if your thoughts about the experience as well as your emotions are included in the writing. It is important to remember that the benefits of this task are more in the long-term rather than in the short-term.

Relaxation Training
Progressive relaxation was taught whereby you learnt to sequentially tense and then relax various groups of muscles throughout your body. This technique was taught to help you recognise the presence of tension as it appears in your everyday life and give you the skills to be able to relieve that tension. Each group of muscles were tensed for about 5 seconds and then the tension was let go all at once and replaced by relaxation. Each muscle group was tensed and relaxed twice.
The order of the muscle groups worked through was as follows...
Right hand and lower arm (then left), Right Bicep (then Left), Forehead, Eyes, Jaws, Neck, Shoulders, Chest, Stomach, Legs and feet.

Techniques for a Better Sleep
The techniques taught were aimed at changing the cues that surround your sleeping behaviour. The techniques involved 1) going to sleep only when you are sleepy. 2)

Not using your bed for anything other than sleep. 3) If unable to sleep, get up and go into another room and return to bed when sleepy. 4) Use progressive relaxation techniques. 5) Get up at the same time in the morning regardless of the amount of sleep you go the night before. 6) Do not nap during the day. 7) If it is worry that is keeping you awake, try writing down what it is that is worrying you and come up with some possible solutions (while you are in the other room) or do your "thought catching". If it is the next day that you are thinking about, write down a plan for the next day with a list of all the things that you need to do. The aim is to deal with whatever it is that is keeping you awake so that you can go to bed and sleep.

Session 8: Assertiveness Training

We learnt that assertiveness was about respecting your-self and others. It involves honestly stating your feelings and your wants while respecting the rights of others. To be assertive we learnt that you needed to...

1. **Know Yourself:** You can only express yourself clearly, directly and appropriately when you know what it is that you believe, think and feel and accept these views and feelings as valid and important.
2. **Take Responsibility:** To be assertive you must realise that you are responsible for your life and your life choices, and therefore cannot blame other people or circumstances for what happens to you.
3. **Decision Making:** Taking responsibility for our thoughts, emotions and behaviours places us in a position to make decisions about them and allows us to change aspects of our life that we are not happy with.

Session 9: Maintenance Program

In this session we identified high-risk situations that may lead you to go shopping. From of all the techniques and strategies taught during the program you chose and applied the ones that they would use to cope with each of the high-risk situations. Therefore when problems do arise you have a strategy and a plan to help you maintain your progress.

Session 9: Handout
Maintenance Plan

During these 10 weeks of intervention you have gained a greater understanding of what causes your shopping behaviour and the types of thoughts, emotions and situations that lead you to go shopping in a compulsive way. You have also learnt a variety of techniques to help you deal with those causes putting you a more powerful position to control your unwanted behaviour. Today we are going write a maintenance plan to help you maintain your progress even when high-risk situations arise.

1. Make a list of the high-risk situations that you may encounter in the future and may cause a relapse in your shopping behaviour.

2. During the last 8 weeks of treatment sessions, a lot of different techniques were taught to help you deal with different areas of your life that lead you to go shopping. Out of the 8 techniques you learnt write down the ones you found most helpful and the ones that you will use to help you through difficult times in the future. (The 8 techniques were: thought catching, active planning, problem solving, budget advice, emotional writing, relaxation training, sleep techniques and assertiveness training).

3. Choose a couple of the situations listed in question one. Explain to the researcher how you would apply one or more of the techniques you have been taught to that situation. As well as explaining why you would apply those particular techniques and the results that you would expect. Write down the plans of action below.

Session 10: Follow-up

Duration: 1 Hour
Objectives & Guidelines:

1. Check and collect daily diaries.

2. Discuss any problems that may have occurred in the last month and discuss the strategies and techniques the participant used to handled them.

3. Handout the psychological tests and questionnaires to be filled out by the participants at home and sent back to the researcher in the following week (envelopes with postage paid provided).

4. Handout evaluation sheets of the psycho-educational program for the participants to fill out and return (separate envelopes with postage paid are provided for the evaluation sheets so that they can be filled out confidentially).

5. Thank the participants for all their hard work and for their commitment (small card and gift was given).

6. Give the participants the token reimbursement for travel expenses to and from the university.

Session 10: Handout
Program Evaluation

1. Have you enjoyed the intervention program? (please circle)

1--------2--------3--------4--------5--------6--------7
NO, NOT VERY MUCH YES, VERY MUCH

2. What did you enjoy about the program?

_____
_____
_____
_____
_____
_____
_____
_____

3. What did you not enjoy about the program?

4. Did you find the program helpful?

1--------2--------3--------4--------5--------6--------7
NO, NOT VERY HELPFUL YES, VERY HELPFUL

5. If yes, What things did you find particularly helpful?

6. If no, What aspects did you not find particularly helpful or of little use?

7. Has the program changed the way you view/understand your shopping behaviour?

1--------2--------3--------4--------5--------6--------7
No Yes

8. If yes, How has your view changed?

9. Do you feel more in control of your shopping behaviour now?

10. What improvements do you think could be made to the program?

11. Would you recommend the program to a friend?

12. Any other comments?

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Appendix 2

Questionnaires & Psychological Tests

Questionnaire on Perceived Impact of Compulsive Shopping

It is important that the researcher obtains your unbiased opinions and for this reason it is preferred that you fill out this questionnaire independently.

Participants Name:

Directions: Please read the questions below and answer each one by writing one of the numbers from the scale that you think best describes how you act and feel.

Scale:

1 – Never 2 – Occasionally 3 – Regularly 4 - Always

1. Do you ever have urges to spend money on any thing at all? ❒
2. Do you ever buy things that you have later found to be useless? ❒
3. Do you ever feel on edge, agitated or irritable when you are unable to buy something? ❒
4. Do you ever avoid certain stores out of fear that you will buy too much? ❒
5. Do you ever ask a friend of family member to go shopping with you to prevent spending too much? ❒
6. Do you ever hide your purchases from family members or friends? ❒
7. Do you ever miss appointments with friends or family because of urges to shop? ❒
8. Do you ever leave your work place in order to buy something? ❒
9. Has any of your purchases ever resulted in problems with your bank? ❒
10. Has any of your purchases resulted in legal problems? ❒
11. Do you regularly regret your purchases? ❒
12. Do you feel tense or nervous before buying something? ❒
13. Do you feel relief after you have bought something? ❒
14. Do you have excessive buying periods accompanied by over whelming feelings of generosity? ❒

15. Would you buy something on the 'spur of the moment' at least once a month? ❑

16. Do your purchases' ever provoke reproach from your family members or friends? ❑

17. Have any of your purchases ever provoked a prolonged misunderstanding or separation from family members or friends? **Please Circle: Yes or No**

18. If Yes, how often in the past 6 months? ❑

This questionnaire has been adapted from the Questionnaire about Buying Behaviour used in the study by Lejoyeux, Tassin, Solomon & Ades (1997).

Compulsive Buying Scale

Please indicate how much you agree or disagree with each of the statements below. Place an X on the line which best indicates how you feel about each statement.

1.a) If I have any money left at the end of the pay period, I just have to spend it

	Strongly agree	**Somewhat agree**	**Neither agree nor disagree**	**Somewhat disagree**	**Strongly disagree**
	_____	_____	_____	_____	_____

Please indicate how often you have done each of the following things by placing an X on the appropriate line.

	Very often	**Often**	**Some-times**	**Rarely**	**Never**
2.a) Felt others would be horrified if they knew of my spending habits.	_____	_____	_____	_____	_____
b) Bought things even when I couldn't afford them	_____	_____	_____	_____	_____
c) Wrote a check when I knew I didn't have enough money to cover it.	_____	_____	_____	_____	_____
d) Bought myself something in order to make myself feel better	_____	_____	_____	_____	_____
e) Felt anxious or nervous on days I didn't go shopping	_____	_____	_____	_____	_____
f) Made only the minimum payments on my credit cards, lay-bys or mortgage	_____	_____	_____	_____	_____

GENERAL HEALTH QUESTIONNAIRE (GHQ-12)

NFER-NELSON
Health & Social Care

Name:..... **Date:** .....

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, over the last few weeks. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently . . .

1. been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less than usual
5. felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8. been able to face up to your problems?	More so than usual	Same as usual	Less so than usual	Much less able
9. been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

Code 4920 03 4

DEPRESSION-ANXIETY-STRESS SCALE

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0. Did not apply to me at all
1. Applied to me to some degree, or some of the time
2. Applied to me a considerable degree, or a good part of the time
3. Applied to me very much, or most of the time

1.	I found myself getting upset by quite trivial things.	0	1	2	3
2.	I just couldn't seem to get going.	0	1	2	3
3.	I had a feeling of faintness.	0	1	2	3
4.	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness) in the absence of physical exertion.	0	1	2	3
5.	I felt sad and depressed.	0	1	2	3
6.	I found it hard to calm down after something upset me.	0	1	2	3
7.	I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion.	0	1	2	3
8.	I found myself getting impatient when I was delayed in any way (e.g., lifts, traffic lights, being kept waiting).	0	1	2	3
9.	I found myself in situations which made me so anxious I was most relieved when they ended.	0	1	2	3
10.	I tended to over-react to situations.	0	1	2	3
11.	I found myself getting upset rather easily.	0	1	2	3
12.	I felt that I had nothing to look forward to.	0	1	2	3
13.	I couldn't seem to experience any positive feeling at all.	0	1	2	3
14.	I found that I was very irritable.	0	1	2	3
15.	I was aware of dryness of my mouth.	0	1	2	3
16.	I felt that I had lost interest in just about everything.	0	1	2	3
17.	I could see nothing in the future to be hopeful about.	0	1	2	3
18.	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat).	0	1	2	3
19.	I felt scared without any good reason.	0	1	2	3

20. I felt that life wasn't worthwhile.	0	1	2	3
21. I felt that I was rather touchy.	0	1	2	3
22. I felt that I was using a lot of nervous energy.	0	1	2	3
23. I couldn't seem to get any enjoyment out of the things I did.	0	1	2	3
24. I had a feeling of shakiness (e.g., legs going to give way).	0	1	2	3
25. I felt down-hearted and blue.	0	1	2	3
26. I found it difficult to work up the initiative to do things.	0	1	2	3
27. I found it hard to wind down.	0	1	2	3
28. I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
29. I had difficulty in swallowing.	0	1	2	3
30. I feared that I would be "thrown" by some trivial but unfamiliar task.	0	1	2	3
31. I felt I was pretty worthless.	0	1	2	3
32. I was unable to become enthusiastic about anything.	0	1	2	3
33. I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
34. I was in a state of nervous tension.	0	1	2	3
35. I felt I was close to panic.	0	1	2	3
36. I felt I wasn't worth much as a person.	0	1	2	3
37. I found it difficult to relax.	0	1	2	3
38. I felt terrified.	0	1	2	3
39. I experienced trembling (e.g., in the hands).	0	1	2	3
40. I found myself getting agitated.	0	1	2	3
41. I felt that life was meaningless.	0	1	2	3
42. I found it difficult to tolerate interruptions to what I was doing.	0	1	2	3

COPE

Name:.....

Date:..... Record Number:.....

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Then respond to each of the following items by choosing one number for each, using the response choices listed just below.

1 = I usually don't do this at all.	2 = I usually do this a little bit.
3 = I usually do this a medium amount.	4 = I usually do this a lot.

Please try to respond to each item separately in your mind from each other item. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Please answer every item. There are no 'right' or 'wrong' answers, so choose the most accurate answer for YOU – not what you think 'most people' would say or do. Indicate what YOU usually do when YOU experience a stressful event.

1. I try to grow as a person as a result of the experience. ☐
2. I turn to work or other substitute activities to take my mind off things. ☐
3. I get upset and let my emotions out. ☐
4. I try to get advice from someone about what to do. ☐
5. I concentrate my efforts on doing something about it. ☐
6. I say to myself "this isn't real". ☐
7. I put my trust in God. ☐
8. I laugh about the situation. ☐
9. I admit to myself that I can't deal with it, and give up trying. ☐
10. I restrain myself from doing anything too quickly. ☐

11. I discuss my feelings with someone. ☐
12. I use alcohol or drugs to make myself feel better. ☐
13. I get used to the idea that it happened. ☐
14. I talk to someone to find out more about the situation. ☐
15. I keep myself from getting distracted by other thoughts or activities. ☐
16. I daydream about things other than this. ☐
17. I get upset, and am really aware of it. ☐
18. I seek God's help. ☐
19. I make a plan of action. ☐
20. I make jokes about it. ☐

21. I accept that this has happened and that it can't be changed. ☐
22. I hold off doing anything about it until the situation permits. ☐
23. I try to get emotional support from friends and relatives. ☐
24. I just give up trying to reach my goal. ☐
25. I take additional action to try to get rid of the problem. ☐
26. I try to lose myself for a while by drinking alcohol or taking drugs. ☐
27. I refuse to believe that it has happened. ☐
28. I let my feelings out. ☐
29. I try to see it in a different light, to make it seem more positive. ☐
30. I talk to someone who could do something concrete about the problem. ☐

31. I sleep more than usual. ☐
32. I try to come up with a strategy about what to do. ☐
33. I focus on dealing with this problem and, if necessary, let other things slide a little. ☐
34. I get sympathy and understanding from someone. ☐
35. I drink alcohol or take drugs, in order to think about it less. ☐
36. I kid around about it. ☐
37. I give up the attempt to get what I want. ☐
38. I look for something good in what is happening. ☐
39. I think about how I might best handle the problem. ☐
40. I pretend that it hasn't really happened. ☐

41. I make sure not to make matters worse by acting too soon. ☐
42. I try hard to prevent other things from interfering with my efforts at dealing with this. ☐
43. I go to the cinema or watch television, to think about it less. ☐
44. I accept the reality of the fact that it happened. ☐
45. I ask people who have had similar experiences what they did. ☐
46. I feel a lot of emotional distress and I find myself expressing those feelings a lot. ☐
47. I take direct action to get around the problem. ☐
48. I try to find comfort in my religion. ☐
49. I force myself to wait for the right time to do something. ☐
50. I make fun of the situation. ☐

51. I reduce the amount of effort I'm putting into solving the problem. ☐
52. I talk to someone about how I feel. ☐
53. I use alcohol or drugs to help me get through it. ☐
54. I learn to live with it. ☐
55. I put aside other activities in order to concentrate on this. ☐
56. I think hard about what steps to take. ☐
57. I act as though it hasn't even happened. ☐
58. I do what has to be done, one step at a time. ☐
59. I learn something from the experience. ☐
60. I pray more than usual. ☐

Appendix 3

Recruitment Advertisement

COMPULSIVE SHOPPERS WANTED

Do you frequently experience irresistible urges to buy?
Do you frequently buy more than you need?
Or more than you can afford?
Does your shopping cause you distress?

Free Help Program Offered

People who are compulsive shoppers are sought to take part in a research program designed to alleviate symptoms of compulsive shopping. The program is based on psychological research investigating the most effective ways individuals learn to change unwanted behaviour.
The intervention program consists of 10 weekly 1 hour sessions and 2 follow –up sessions. The program will be free of charge to all those participating.

For More Information Please Contact
Megan Garner: (03) 364 2550
This research program is part of the requirement for a masters of Science degree in psychology and is under the supervision of Neville Blampied. The intervention program has the approval of the University of Canterbury Human Ethics Committee.

COMPULSIVE SHOPPERS WANTED

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Or buy more than you need?
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Appendix 4

Letter of Ethical Approval

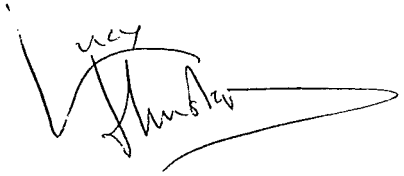
To: Megan Garner
From: Lucy Johnston (for Research Committee)
Re: Thesis Proposal
Date: 15th April, 1999
CC: Neville Blampied, Steve Hudson, Robyn Daly

Megan
Both Steve Hudson and I have now reviewed your thesis proposal and we are happy to approve it. However, there are a number of points raised in our reviews which you may wish to discuss with your supervisor before embarking on the project. These are detailed below.

- This is an ambitious task for an MA thesis.
- There is a lack of detail concerning quite central issues in how the thesis is to be carried out. For example, how is the multiple baseline across subjects to be set up, are the 12 sessions going to be individualized (would seem a pity for efficiency sake as well as good therapy process), if not how are you going to prevent contamination. The functional analysis of episodes of the problem behavior process (as we have called it in the past); I would need to know what prompts are to be used, how the interview is going to be structured etc, and what qualitative techniques are to be used in the analysis of the resulting data. If you wish to discuss these points further please see Steve Hudson.
- We suspect (but do not know) that advertising in GPs rooms and the hospital may involve getting ethics approval from the relevant bodies (RCGP and SRHA) which is never a lot of fun. Same with relevant "Christchurch clinicians" (who are probably treating these people anyway).

Budget:
The following items have been approved. Please see Robyn Daly to organize reimbursement. Note that your travel cost estimations have been revised in line with the formula in the PG handbook.

Psychological tests	$ 52.50
Questionnaire printing	$ 29.34
Diary printing	$ 98.40
Audio Cassettes	$ 60.00
Postage (12 @ $0.80) & envelopes (12 @ $0.50)	$ 15.60
Travel costs (240 km @ $0.87 per 10km x 12 participants)	$250.56
Total	**$616.96**



Appendix 5

Programme Evaluations

Program Evaluation

1. Have you enjoyed the intervention program? (please circle)

1--------2--------3--------4--------5--------6-------(7)
No, not very much Yes, very much

2. What did you enjoy about the program?

I was shown the reasons (or made aware of the reasons) for my shopping in a kind and understanding way. I learned more about myself eg. who I really am and what I really want for my life. I also enjoyed just talking about all the things that exited or bothered me and my plans for the future. I really looked forward to these sessions.

3. What did you not enjoy about the program?

I enjoyed most of it. The one session where we received "homework" was a waste of time, in my opinion. It would have been more helpful if we could all ask questions and the lady, Carol's boss, then all. She was unprepared (she stated so herself) and answered only one person's questions.

4. Did you find the program helpful?

1--------2--------3--------4--------5--------6-------(7)
No, not very helpful Yes, very helpful

5. If yes, What things did you find particularly helpful?

When I realized (was learnt to realize) that most of my spending on small things, were to actually ~~replace~~ make up for the fact that I couldn't buy most of the things I really needed. I also started changing my thought pattern and are able to deal with my emotions easier. It helped me to set goals and achieve them.

6. If no, What aspects did you not find particularly helpful or of little use?

All helpfull

7. Has the program changed the way you view/understand your shopping behaviour?

1--------2--------3--------4--------5--------6--------7
No Yes

8. If yes, How has your view changed?

I now only buy the things I really needed ~~want~~. I always ask myself how I will be able to get rid of the item if I don't want it anymore or have to move. I will rather buy the more expensive item I really want, than to spend less money on cheaper stuff that will break easily and will have to be replaced sooner. I spend more on myself now. (I need to.)

9. Do you feel more in control of your shopping behaviour now?

Yes, definately. I quite enjoy walking around browsing but not buying and would add in my head all the money I'm saving for that more expensive item I really want (I find almost always really basic stuff like clothing and shoes that are durable, fit well and look good on me.)

10. What improvements do you think could be made to the program?

The program should always be completely (individual) on one-on-one. One would find it difficult to talk about certain things in a group situation. The "budget" session should be replaced by a visit from a budget-counselor to the person's home. The service should be free and ongoing (if the person agrees to it.)

11. Would you recommend the program to a friend?

Definitely. Would not use the word "compulsive" though.

12. Any other comments?

Thanks very much for all of this. It's already making a big difference.

Program Evaluation

1. Have you enjoyed the intervention program? (please circle)

1--------2--------3--------4--------5--------6--------(7)

No, not very much — Yes, very much

2. What did you enjoy about the program?

Knowing your not the only one.
Having someone to confide in. to be
totally honest with.
A way through problems.
Being able to change ways we do things

3. What did you not enjoy about the program?

Some of the homework. Time it took.
Relaxing program.

4. Did you find the program helpful?

1--------2--------3--------4--------5--------(6)--------7

No, not very helpful — Yes, very helpful

5. If yes, What things did you find particularly helpful?

Daily Diary.
Thought catching
emotional working.
Brain storming.
Megan.

6. If no, What aspects did you not find particularly helpful or of little use?

7. Has the program changed the way you view/understand your shopping behaviour?

1--------2--------3--------4--------5--------6----(7)

No Yes

8. If yes, How has your view changed?

Realising I have a problem, There Are ways of overcoming this behaviour. Skills can be used in other areas. Given more confidence

9. Do you feel more in control of your shopping behaviour now?

Yes.

10. What improvements do you think could be made to the program?

11. Would you recommend the program to a friend?

Yes.

12. Any other comments?

I found Megan very helpful and encouraging.

Program Evaluation

1. Have you enjoyed the intervention program? (please circle)

1--------2--------3--------4--------5--------(6)--------7
No, not very much Yes, very much

2. What did you enjoy about the program?

I enjoyed talking to Megan And all so Finding Out more about my self.

3. What did you not enjoy about the program?

Nothing

4. Did you find the program helpful?

1--------2--------3--------4--------5--------(6)--------7
No, not very helpful Yes, very helpful

5. If yes, What things did you find particularly helpful?

It made me look at why I shop

6. If no, What aspects did you not find particularly helpful or of little use?

7. Has the program changed the way you view/understand your shopping behaviour?

1--------2--------3--------4--------5--------(6)--------7

No Yes

8. If yes, How has your view changed?

I watch what I buy now.

9. Do you feel more in control of your shopping behaviour now?

yes.

10. What improvements do you think could be made to the program?

Less diary keeping.

11. Would you recommend the program to a friend?

yes

12. Any other comments?

12. Does ___ ___ appear to have excessive buying periods accompanied by over whelming feelings of generosity? ❑

13. Does _____ _ buy something on the 'spur of the moment' at least once a month? ❑

14. Have any of the purchases' ever provoked reproach from his/her family members or friends? ❑

15. Have any of the purchases ever provoked a prolonged misunderstanding or separation from family members or friends? **Please Circle: Yes or No**

16. If yes; how often in the past 6 months? ❑

Dear Megan,

Since ____ started on the course, she has gone flatting
, I find the questions hard to answer, however she has
lked to me a lot as she has gone through the 10 weeks
t has been wonderful, as she has stopped and
assessed herself and revaluated, not only her shopping problem
of many areas in her life, It certainly has made
realise that she is very capable in her work
vironment, to do the job she has been asked to
, and not underestimate her own capabilities
I would like to personally thank you, for
ing her though this course, as I can see many
g term benifit, and the shopping part only a very
ll fraction of it.

Thank you

Program Evaluation

1. Have you enjoyed the intervention program? (please circle)

1--------2--------3--------4--------5--------6--------7
No, not very much Yes, very much

2. What did you enjoy about the program?

→ The one ~~of~~ on one of the researcher and the "subject"
→ The helpful ideas and suggestions that came out during the programme.
→ The proffessional yet friendly attitude of the researcher.

3. What did you not enjoy about the program?

Not applicable

4. Did you find the program helpful?

1--------2--------3--------4--------5--------6--------7
No, not very helpful Yes, very helpful

5. If yes, What things did you find particularly helpful?

- emotional writing
- relaxation training
- problem solving -> brain storming

6. If no, What aspects did you not find particularly helpful or of little use?

7. Has the program changed the way you view/understand your shopping behaviour?

1--------2--------3--------4--------5--------6--------7
No Yes

8. If yes, How has your view changed?

I now understand some of the "triggers" or reasons why I want to go shopping and thanks to the strategies I have learn't I am able to divert my attention to something different other than going shopping

9. Do you feel more in control of your shopping behaviour now?

Yes I do.

10. What improvements do you think could be made to the program?

None that I can think of.

11. Would you recommend the program to a friend?

yes I would.

12. Any other comments?

Program Evaluation

1. Have you enjoyed the intervention program? (please circle)

1--------2--------3--------4--------5--------(6)--------7
No, not very much Yes, very much

2. What did you enjoy about the program?

It gave me an insight into my behaviour behind the shopping. The exercises really gave me a chance to explore myself.

3. What did you not enjoy about the program?

Its made me disorganised in some areas and very organised in others.

4. Did you find the program helpful?

1--------2--------3--------4--------5--------(6)--------7
No, not very helpful Yes, very helpful

5. If yes, What things did you find particularly helpful?

The thought catching exercises The emotional writing - These all gave me a way of organising my thoughts and emotions as they surfaced.

6. If no, What aspects did you not find particularly helpful or of little use?

7. Has the program changed the way you view/understand your shopping behaviour?

1--------2--------3--------4--------5--------6------(7)
No Yes

8. If yes, How has your view changed?
In my view shopping was the one level constant in a very disorganised and stressful life.

9. Do you feel more in control of your shopping behaviour now?
Yes - although I still have moments when I would love to shop.

10. What improvements do you think could be made to the program?
It could be done over a longer period of time. I felt that 10 weeks was just starting to put the exercises into practise. More could be done with follow up. (if there was more time)

11. Would you recommend the program to a friend?
Yes - I already have!!

12. Any other comments?
I found this very beneficial. It gave me a chance to rediscover a piece of myself that was missing. I now shop less and have become more assertive - A big thanks to Megan!!